

FOR STATE
HEALTH DEPT.

THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PM3. PAGE 5 MAY BE RETAINED FOR YOUR FILES.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>La</u> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Orleans</u>	
c. LENGTH OF STAY IN 1b <u>2 day</u>		d. STREET ADDRESS <u>4808 Carmette St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium & Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine Weaver Adams</u>	4. DATE OF DEATH <u>Aug 7 1960</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-06</u>	9. AGE (In years last birthday) <u>54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>John Hyde</u>		14. MOTHER'S MAIDEN NAME <u>Sally Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hosp. Record.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE, MASSIVE, THORACIC CAVITIES, BILATERAL</u>			
DUE TO (b) <u>LACERATIONS, MULTIPLE, LEFT LUNG & BILATERAL PARIETAL PLEURA</u>			
DUE TO (c) <u>FRACTURES, MULTIPLE, RIBS, BILATERAL</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injury of auto. struck by oncoming vehicle</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:45 p.m. 8-5-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Langley Pk</u> (County) <u>P. Y.</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8-9-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cent</u>		22d. LOCATION (City, town, or country) <u>Pasco Co</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR <u>James W. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>AUG 10 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

MEDICAL CERTIFICATION

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY Trenton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 93 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 51 Kelsey Avenue	
3. NAME OF DECEASED (Type or print) First Annie Middle Mae Last Adkison		4. DATE OF DEATH Month August Day 20 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Housewife)		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) yrs. 35 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Deberry		14. MOTHER'S MAIDEN NAME Anna N. Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral & intra-abdominal hemorrhage DUE TO (b) Choriocarcinoma DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 173X		INTERVAL BETWEEN ONSET AND DEATH hours 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 19 60 , to August 20, 19 60 , that I last saw the deceased alive on August 20, 19 60 , and that death occurred at 9:10a M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/20/60 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-22-60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Adel, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE Frazier Funeral Home, Inc.		ADDRESS 389-R. 2 Ave NW	
24a. REC'D BY REGISTRAR DATE AUG 24 '60		24b. REGISTRAR'S SIGNATURE G. L. S. Kline	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of medical examiner		11. Signature of coroner		12. Signature of jury	
13. Signature of witness		14. Signature of witness		15. Signature of witness		16. Signature of witness	
17. Signature of witness		18. Signature of witness		19. Signature of witness		20. Signature of witness	
21. Signature of witness		22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness		28. Signature of witness	
29. Signature of witness		30. Signature of witness		31. Signature of witness		32. Signature of witness	
33. Signature of witness		34. Signature of witness		35. Signature of witness		36. Signature of witness	
37. Signature of witness		38. Signature of witness		39. Signature of witness		40. Signature of witness	
41. Signature of witness		42. Signature of witness		43. Signature of witness		44. Signature of witness	
45. Signature of witness		46. Signature of witness		47. Signature of witness		48. Signature of witness	
49. Signature of witness		50. Signature of witness		51. Signature of witness		52. Signature of witness	
53. Signature of witness		54. Signature of witness		55. Signature of witness		56. Signature of witness	
57. Signature of witness		58. Signature of witness		59. Signature of witness		60. Signature of witness	
61. Signature of witness		62. Signature of witness		63. Signature of witness		64. Signature of witness	
65. Signature of witness		66. Signature of witness		67. Signature of witness		68. Signature of witness	
69. Signature of witness		70. Signature of witness		71. Signature of witness		72. Signature of witness	
73. Signature of witness		74. Signature of witness		75. Signature of witness		76. Signature of witness	
77. Signature of witness		78. Signature of witness		79. Signature of witness		80. Signature of witness	
81. Signature of witness		82. Signature of witness		83. Signature of witness		84. Signature of witness	
85. Signature of witness		86. Signature of witness		87. Signature of witness		88. Signature of witness	
89. Signature of witness		90. Signature of witness		91. Signature of witness		92. Signature of witness	
93. Signature of witness		94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness		100. Signature of witness	

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9318
CERTIFICATE OF DEATH

09220

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Walden Lee AINSWORTH				4. DATE OF DEATH Month Day Year August 7 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-86	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William G. Ainsworth				14. MOTHER'S MAIDEN NAME Mary Walden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes WWI & WWII				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) abdominal metastases DUE TO Carcinoma of the bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1810 (c) 5 yrs.							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 7-4-60 to 8-7- 19 60 , that (I) (we) last saw the deceased alive on 8-7- 19 60 , and that death occurred at 10:40 AM from the causes and on the date stated above.							
22a. SIGNATURE H. S. Irons				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-8-60	
22c. PHYSICIAN'S NAME (Type) H. S. IRONS, LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY				25a. REC'D BY REGISTRAR DAUG 9 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Keane	

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1. **FOR STATE HEALTH DEPT.** **(M)**
Certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
TO DEPUTY MEDICAL EXAMINER: Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
9244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09222										
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN lb 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			d. STREET ADDRESS 3532 GREENLY STREET		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3532 GREENLY STREET					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY ELIZABETH ALLEN			First Middle Last		4. DATE OF DEATH AUGUST 21 19 60		Month Day Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/10/87		9. AGE (In years last birthday) 73 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES CLERK (retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) FLINT HILL, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JAMES W. BOWEN					14. MOTHER'S MAIDEN NAME MARGARET E. RHODES					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. David H. Carey, D-139-E Halliday Dr. Brookeville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Interval between onset and death 2 hours at home DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma - yrs.										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Frank J. Broschart M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) FRANK J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DATE SIGNED 8-21-60					
					Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 8/24/60		22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or country) (State) WASHINGTON, D.C.			
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. Raymond A. Giska					ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR AUG 25 '60		24b. REGISTRAR'S SIGNATURE C. E. Long & House	

NOV 19 1944
U.S. AIR FORCE
HONOLULU, HAWAII

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JAMES H. WHITE

SALES (1944)

WHITE, JAMES H.

WHITE

WHITE

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WHITE, JAMES H.

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WHITE, JAMES H.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
09223

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington Grove</i>				c. LENGTH OF STAY IN 1b <i>22 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Admitt</i> First <i>Myra</i> Middle <i>C</i> Last <i>E</i>				4. DATE OF DEATH <i>August - 30 - 1960</i> Month <i>August</i> Day <i>30</i> Year <i>1960</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct - 14 - 1869</i>	9. AGE (In years last birthday) <i>90</i> yrs.	10. IF UNDER 1 YEAR <i>9</i> Months <i>18</i> Days <i>15</i> Hours <i>—</i> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>House - baking Warren Co., Va</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
13. FATHER'S NAME <i>William A. Compton</i>				14. MOTHER'S MAIDEN NAME <i>Laura Bolen</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>none</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>senile debility</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Asteno-sclerosis - generalized</i> (c) <i>Arthritis + nephrosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i> <i>years</i> <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan - 1 - 1937</i> to <i>Aug - 30 - 1960</i> , that (I) (we) last saw the deceased alive on <i>Aug - 30 - 1960</i> , and that death occurred at <i>8 P.</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>William E. Miller</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>WILLIAM E. MILLER</i>	
				22d. ADDRESS <i>7-Brooks Ave., Gaithersburg, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept. 2 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Front Royal Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber</i>				ADDRESS <i>Laytonsville, Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 2 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Anthony L. Harris</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

9321

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09224

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Orlando ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 913 Buckwood Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Dean Last Anderson		4. DATE OF DEATH Month August Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November, 30, 1942
9. AGE (In years last birthday) 17 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard H. Anderson		14. MOTHER'S MAIDEN NAME Lorraine M. Schuman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease with Aortic Stenosis & DUE TO (c) Patent Ductus Arteriosus INTERVAL BETWEEN ONSET AND DEATH 30 Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 31 1960 to August 4 1960 that (I) (we) last saw the deceased alive on August 4 1960 , and that death occurred at 2:30p M, from the causes and on the date stated above.			
22a. SIGNATURE Benson R. Wilcox		22b. DATE SIGNED 8-5-60	
22c. PHYSICIAN'S NAME (Type) BENSON R. WILCOX, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		23b. DATE THEREOF 8/5/60	
23c. NAME OF CEMETERY OR CREMATORY Orlando, Florida		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE AUG 8 '60		25c. REGISTRAR'S SIGNATURE Catharine S. Harris	

TO DEPUTY MEDICAL EXAMINER: please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9262

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09225

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>21</u>				d. STREET ADDRESS <u>1812 Patton Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PAQUALE</u>		First <u>PAQUALE</u> Middle <u>NMN</u> Last <u>AQUILINO</u>		4. DATE OF DEATH <u>AUG 1 1960</u>		Month <u>AUG</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Italian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10 April 19, 1884</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u>		IF UNDER 24 HRS. Hours <u>76</u> Min. <u>76</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>Naples Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer. U.S.</u>	
13. FATHER'S NAME <u>Disantis Zachary Aquilino</u>				14. MOTHER'S MAIDEN NAME <u>Disantis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>44-277-213</u>		17. INFORMANT <u>Zachary Aquilino-5405 -21st Ave. Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bloschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Bloschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>8-2-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/4/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
						22d. LOCATION (City, town, or country) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR <u>The S. H. Hines Co. Washington, D. C.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

1955

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The U. S. Marine Corps, Washington, D. C.
August 2, 1955
Major General, U. S. Marine Corps, Washington, D. C.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9322

09226

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 67 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY 85X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg d. STREET ADDRESS Route 4, Box 300AA e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Elizabeth Last Armstrong		4. DATE OF DEATH Month August Day 15 Year 19 60					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1908	9. AGE (In years lost birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 24 Days 15 Hours 15 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dennis Rinker		14. MOTHER'S MAIDEN NAME Betty Rinker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure Secondary to Hypertension DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Squamous Carcinoma, Primary Unknown DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 hours 22 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June 9, 1960			
20f. (City or town) August 15, 1960		20g. (County) W. Va.		20h. (State) W. Va.			
21. I certify that (I) (this hospital) attended the deceased from June 9, 1960 to August 15, 1960 , that (I) (we) last saw the deceased alive on August 15, 1960 , and that death occurred on August 15, 1960 at 6:15 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Vincent H. Bono Jr.		22b. DATE 8-15-60		22c. PHYSICIAN'S NAME (Type) Vincent H. Bono, Jr., M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-18-60		23c. NAME OF CEMETERY OR CREMATORY Rosedale			
23d. LOCATION (City, town, or county) Martinsburg		23e. (State) W. Va.					
24. FUNERAL DIRECTOR'S SIGNATURE Howard R. Brown		ADDRESS Martinsburg, W. Va.		25a. REC'D BY REGISTRAR DATE AUG 18 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus							

9432

CERTIFICATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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AGE

EDUCATION

THE CLINICAL CENTER, BOSTON, MASS.

DATE OF DEATH

PLACE OF DEATH

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THE CLINICAL CENTER, BOSTON, MASS.

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THE CLINICAL CENTER, BOSTON, MASS.

DATE OF DEATH

9323

CERTIFICATE OF DEATH

Reg. Dist. No.

09227

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b X Rural-Germantown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS Oak Crest Trailer Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) INFANT BOY ASBURY				4. DATE OF DEATH August 3, 1960 Month August Day 3 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1960		9. AGE (In years last birthday) 14 yrs.	IF UNDER 1 YEAR Months 14 Days 25	IF UNDER 24 HRS. Hours 25 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Henry D. Asbury				14. MOTHER'S MAIDEN NAME Annie E. Brewster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		INFORMANT Henry D. Asbury-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ATELECTASIS 7/2.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) PREMATURITY DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 14 hr. 25 min. 14 hr. 25 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from AUG 3, 1960 to AUG 3, 1960 , that I last saw the deceased alive on AUG 3, 1960 , and that death occurred at 6:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3716 HOWARD AVE. KENSINGTON, MD DATE SIGNED 8-4-60 ACTUAL SIGNATURE Robert O. Warthen M.D. PHYSICIAN'S NAME (Type) ROBERT O. WARTHEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/60		22c. NAME OF CEMETERY OR CREMATORY Rich Valley Church Cem. Smith County, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler-1331 E. Montgomery Ave. Rockville, Md.				24a. REC'D BY REGISTRAR DATE AUG 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10033

CERTIFICATE OF BIRTH

9827



[Faint, illegible text and lines, likely a birth certificate form with fields for name, date, and location.]

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09228

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				c. LENGTH OF STAY IN 1b ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) Wheaton Nursing Home 11901 Georgia Ave.,				d. STREET ADDRESS 2032 Belmont Road, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minna Middle Niemann Last Baggs				4. DATE OF DEATH Month Aug. Day 11 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/1888	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months --- Days ---		11. IF UNDER 24 HRS. Hours --- Min. ---			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Niemann				14. MOTHER'S MAIDEN NAME Marie Diemer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 578-03-5549A			
17. INFORMANT William E. Niemann				Address 174 S. Orange Ave. South Orange, N.J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Decedent 331X DUE TO Anterior Sclerosis Generalized years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 331X DUE TO Anterior Sclerosis Generalized years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Carcinoma Tongue - Squamous Cell INTERVAL BETWEEN ONSET AND DEATH 1 year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 7-3-60 to 8-11-60 , that (I) (we) last saw the deceased alive on 8-9-60 , and that death occurred at 6:45 from the causes and on the date stated above.							
22a. SIGNATURE R.E. Dunkley				22b. ADDRESS 1746 - R St NW			
22c. PHYSICIAN'S NAME (Type) R.E. Dunkley				22d. ADDRESS 1746 - R St NW			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 8/13/60		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
23d. LOCATION (City, town, or county) (State) Washington, D.C.							
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25a. REC'D BY REGISTRAR AUG 15 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	
ADDRESS Wash. DC							

83028

CERTIFICATE OF DEATH

83028

(M)

Month-year

Location

Questioning No. 0

Birth

Stomach Bacteria

Family White

Misconduct

W. Alan H. H. H.

(I)

No.

19-11-1918

19-11-1918

19-11-1918

19-11-1918

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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9325
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09229

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS 2220 20th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Miriam Middle Frye Last BALLARD				4. DATE OF DEATH Month August Day 22 Year 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-21-84	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.		IF UNDER 24 HRS. Hours 9 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melville BALLARD				14. MOTHER'S MAIDEN NAME Grace Ann FREEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Walter E. BALLARD, Same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 194X IMMEDIATE CAUSE (a) CARCINOMA THYROID DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-25- 1960 to 8-22- 1960 , that (I) (we) last saw the deceased alive on 8-22- 1960 , and that death occurred at 2:08 PM from the causes and on the date stated above.							
22a. SIGNATURE Larry J. Hines				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-23-60	
22c. PHYSICIAN'S NAME (Type) Larry J. HINES, CDR, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 8/25/60		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY		23d. LOCATION (City, town, or county) (State) PRINCE GEORGES COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong				ADDRESS 1300 N St., N.W., Wash. D.C.		25a. REC'D BY REGISTRAR AUG 24 '60	
				25b. REGISTRAR'S SIGNATURE L. Hines			

List 10: 051 Lower 1, 2, 3

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U.S. Dept., B. I.

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9263
09230
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>1 mo 12 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Ter. Unit Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10208 Sutherland Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>William</u> Last <u>Bates</u>		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-11</u>	9. AGE (In years lost birthday) <u>48</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ny</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Louis Bates</u>			14. MOTHER'S MAIDEN NAME <u>Helen O'Connor</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW # 2 577-07-7398</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>432x</u> DUE TO <u>Pericardial effusion (pericarditis)</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. DUE TO <u>Septicemia</u> (c) <u>Laennec's cirrhosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 17, 1960</u> to <u>AUG 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>AUG. 29, 1960</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Morrill C. Quinnam Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-29-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>MORRILL C. QUINNAM, JR.</u>		22d. ADDRESS <u>7600 CARROLL AVE. TAKOMA PARK, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/2/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>			
23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>WAGNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 6 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

USA

CERTIFICATE OF DEATH

11-130

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words are difficult to decipher but appear to include:]

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
DATE OF BIRTH
PLACE OF BIRTH
SEX
AGE
EDUCATION
OCCUPATION
RELIGION
DATE OF MARRIAGE
NAME OF SPOUSE
NAME OF CHILDREN
NAME OF NEXT OF KIN
NAME OF PHYSICIAN
NAME OF BURIAL PLACE
NAME OF MINISTER
NAME OF WITNESSES
NAME OF REGISTRAR
NAME OF OFFICIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: How requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9326

CERTIFICATE OF DEATH

09231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, MD RD #3</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clayton Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marquerite</u> First <u>Toutant</u> Middle <u>Beauregard</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>6</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>New Orleans, La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rene T. Beauregard</u>		14. MOTHER'S MAIDEN NAME <u>Alice Cemar</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. J. B. Diamond, Quince Orchard, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Bronchial</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rt. Hemiplegia</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 days</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>3 Aug.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2 Aug.</u> , 19 <u>60</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Barnesville, Md.</u> DATE SIGNED <u>3 Aug 60</u> ACTUAL SIGNATURE <u>Gordon M. Smith</u> M.D. PHYSICIAN'S NAME (Type) <u>Gordon M. Smith</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 5, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cloppers, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>316 E. Diamond Ave Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

(M)

1000

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09232

9327

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 1 HOUR d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SENECA d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELMER Middle CORNELIUS Last BELL			4. DATE OF DEATH Month AUGUST 26 Day 160 Year 1960				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/85	9. AGE (In years lost birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 7 Days 14 Hours 15 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Nathaniel Wesley Bell				
14. MOTHER'S MAIDEN NAME Elizabeth Ellen Perry			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 219-03-1432			17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of right coronary artery 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, left lower lung					INTERVAL BETWEEN ONSET AND DEATH 4 hours		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Aug. 26, 1960 to Aug. 26, 1960 , that (I) (we) last saw the deceased alive on Aug. 26, 1960 , and that death occurred at 8:39 PM , from the causes and on the date stated above.					
22a. SIGNATURE Charles S. Whitaker 22c. PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.			22b. DATE SIGNED 8/27/60 22d. ADDRESS CLARKSVILLE, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-30-1960		23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery			
23d. LOCATION (City, town, or county) (State) Monrovia Fred. Co. Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey ADDRESS Frederick, Maryland					
25a. REC'D BY REGISTRAR AUG 31 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

0053

CERTIFICATE OF DEATH

1911



DEPARTMENT OF HEALTH

IN THE CITY OF

WASHINGTON

DEPARTMENT OF HEALTH

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DEPARTMENT OF HEALTH

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9328

CERTIFICATE OF DEATH

09233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6hours20min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 6745 G reentree Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Van Tuyt Pain Hart BIEN		4. DATE OF DEATH Month Day Year 8/19 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/87
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4	11. IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Morris Bien		14. MOTHER'S MAIDEN NAME Lilla Viola Hart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Batman Bien		Address Dobbs Ferry N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction, ant-hat, massive 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) arteriosclerosis & hypertension DUE TO (c) diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 12 hrs 20 yrs. 5 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1954 to 19 AUG 1960 , that I last saw the deceased alive on 19 AUG 1960 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norfolk Building Bethesda, Maryland DATE SIGNED 8/19/60 ACTUAL SIGNATURE John M. Wyman M.D. PHYSICIAN'S NAME (Type) John M. Wyman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 8/22/1960	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert S. Humphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE AUG 23 '60		24b. REGISTRAR'S SIGNATURE William S. Knaus	

1933

CERTIFICATE OF DEATH

John M. Wynne
Born [illegible]
Died [illegible]
Cause of Death [illegible]
Place of Death [illegible]
Buried [illegible]
Age [illegible]
Sex [illegible]
Race [illegible]
Marital Status [illegible]
Occupation [illegible]
Education [illegible]
Religion [illegible]
Signature of Physician [illegible]
Signature of Registrar [illegible]
Date [illegible]

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John M. Wynne

John M. Wynne

John M. Wynne

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9304
CERTIFICATE OF DEATH

09234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Kensington</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LETHIA</u> First Middle Last <u>BLAND</u>				4. DATE OF DEATH <u>AUG 22</u> Month Day Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 7, 1904</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Phillip Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Mildred ADAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIOGENIC CARCINOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1 day</u> 19 <u>60</u> , to <u>22 day</u> 19 <u>60</u> , that I last saw the deceased alive on <u>19 day</u> 19 <u>60</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Horace W. Bernton</u> M.D. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton, M. D. 10511 Summit Avenue, Kensington, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knap</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

DEATH RECORD

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form No. 1

DEATH RECORD

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9329

CERTIFICATE OF DEATH

09235

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND		c. LENGTH OF STAY IN 1b 7/30/60-8/31/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND-NURSING HOME		d. STREET ADDRESS 10203-BROOKMOOR DR	
3. NAME OF DECEASED (Type or print) First HENRY Middle JOHN Last BIEBER		4. DATE OF DEATH Month 8 Day 31 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR self-employed		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY Bieber		14. MOTHER'S MAIDEN NAME MARIA MANNINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Mrs. Carlotta B. Jackson, 10,203 Brookmoor Dr. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO UREMIA Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Generalized Arteriosclerosis (b) Generalized Arteriosclerosis (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 days 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) Cerebrovascular Accident			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 31, 1960 to Aug 31, 1960 , that I last saw the deceased alive on Aug 29, 1960 , and that death occurred at 9:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1019 University Boulevard, East 8/24/60 DATE SIGNED 8/24/60			
ACTUAL SIGNATURE Boris Robkin		M.D. 1019 University Boulevard, East 8/24/60	
PHYSICIAN'S NAME (Type) BORIS ROBKIN		Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/2/60	
22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE SEP 6 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CENTRAL DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09236

9264

CERTIFICATE OF DEATH

Reg. Dist. No.

09200

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Haven Rest Home 7300 Baltimore Avenue		d. STREET ADDRESS 1673 Columbia Road, N.W.	
3. NAME OF DECEASED (Type or print) First Beatrice Middle Larman Last Bliss		4. DATE OF DEATH Month August Day 1 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 8, 1880
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY P.B.X. Operator	
11. BIRTHPLACE (State or foreign country) Unobtainable		12. CITIZEN OF WHAT COUNTRY? Unobtainable	
13. FATHER'S NAME ----- Larman		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-32-7588	
17. INFORMANT Clarence G. Brown		Address Washington, DC 2702 Wisconsin Ave. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Congestive Heart Failure DUE TO (c) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 24 hrs Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Semility - Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 1 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 24 , 19 59 , to Aug 1 , 19 60 , that I last saw the deceased alive on Aug 1 , 19 60 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip E. Jones M.D.		ADDRESS (Street, city or town, state) 918 Ellsworth Drive DATE SIGNED 8/1/60	
PHYSICIAN'S NAME (Type) Philip F. Jones		Silver Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR DATE AUG 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9245

CERTIFICATE OF DEATH

Reg. Dist. No. 09237

1. PLACE OF DEATH a. COUNTY xx Montgomery Co. Md. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Althea Woodland Nursing Home				d. STREET ADDRESS 4323 Tuckerman Street			
3. NAME OF DECEASED (Type or print) First Jennie Middle Elsie Last Bowen				4. DATE OF DEATH Month August Day 11 Year 19 60			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-1872	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME G. W. Brown				14. MOTHER'S MAIDEN NAME Laura Loane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		INFORMANT Address G. Carville Bowen Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (p), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 26 , 19 52 , to Aug. 11 , 19 60 , that I last saw the deceased alive on 8-11 , 19 60 , and that death occurred at 1:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David S. Clayman		ADDRESS (Street, city or town, state) DATE SIGNED 6311 Balt. Ave. Riverdale, Md. 8/11/60					
PHYSICIAN'S NAME (Type) David S Clayman		Riverdale, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE AUG 16 '60		24b. REGISTRAR'S SIGNATURE Carroll S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9330 CERTIFICATE OF DEATH

09238

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 7 Months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY Clinton	
3. NAME OF DECEASED (Type or print) First Middle Last Bobby Joe BOWLING		4. DATE OF DEATH Month Day Year August 10 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-34
9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul BOWLING		14. MOTHER'S MAIDEN NAME Lila HENDERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary fibrosarcoma right thigh DUE TO (c) 9 months		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-6- 1960 , to 8-10 1960 , that (I) (we) last saw the deceased alive on 8-10- 1960 , and that death occurred at 5:20AM on the causes and on the date stated above.			
22a. SIGNATURE Kenneth F. Spence, Jr.		22b. DATE SIGNED 8/10/60	
22c. PHYSICIAN'S NAME (Type) KENNETH F. SPENCE, Jr.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-13-60	
23c. NAME OF CEMETERY OR CREMATORY Rose Lawn		23d. LOCATION (City, town, or county) (State) Peadmont, S.C.	
24. FUNERAL DIRECTOR'S SIGNATURE CHAMBERS FUNERAL HOME, 1400 Chapin St., N.W., Wash. D.C.		25a. REC'D BY REGISTRAR DATE AUG 15 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hays			

CERTIFICATE OF DEATH

1930

(M)

Home

South Carolina

Rockledge (Mrs.)

Y. M. W. A.

Clinton

U. S. Naval Hospital

111 Broadway St.

Body

2-24-34

Male

U. S. Navy

U. S. Navy

South Carolina

Paul H. H. H.

Paul H. H. H.

For

John

John

Navy Hospital

(S)

1-10-34

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

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9331
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09239

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 151 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5513 Northfield Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Thomas Middle Martin Last Boyd, Jr.				4. DATE OF DEATH Month August Day 5 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 21, 1953	
9. AGE (In years last birthday) 6		IF UNDER 1 YEAR Months 11 Days 14		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Martin Boyd, Sr.				14. MOTHER'S MAIDEN NAME Carolyn Bryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphatic Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 Year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 7, 1960 to August 5, 1960 , that (I) (we) last saw the deceased alive on August 5, 1960 , and that death occurred at 8:20p M, from the causes and on the date stated above.							
22a. SIGNATURE <i>W. Walter Oppelt</i>				22b. DATE SIGNED 8-6-60			
22c. PHYSICIAN'S NAME (Type) W. WALTER OPPELT, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-8-60		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i> 1557 Wisc Ave Bethesda Md				25a. REC'D BY REGISTRAR DATE AUG 9 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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MAINTENANCE DEPARTMENT OF HEALTH
GENERAL INVESTIGATION AND RESEARCH
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VR A15 (4)
15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 1643-2 d. STREET ADDRESS 2408 - 57th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Last Bradshaw		4. DATE OF DEATH Month August Day 2 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30, 1916 May 31, 1917
9. AGE (In years lost birthday) 43		10. IF UNDER 1 YEAR Months 4 Days 14 Hours 14 Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph R. Willis		14. MOTHER'S MAIDEN NAME Marie Redwine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Carcinoma, breasts - bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Metastatic to bone & soft tissue DUE TO 9 months (c) 170x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, anemia INTERVAL BETWEEN ONSET AND DEATH hours			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from August 1, 19 60 to August 2, 19 60 , that (I) (we) last saw the deceased alive on August 2, 19 60 and that death occurred at 9:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Haskins K. Kashima		22b. DATE SIGNED 8/3/60	
22c. PHYSICIAN'S NAME (Type) Haskins K. Kashima, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-5-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Ft Myer, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		25a. REC'D BY REGISTRAR DATE AUG 5 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. K...			

00240

CERTIFICATE OF DEATH

3182



John George

Married

Married

Married

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9333
CERTIFICATE OF DEATH

09241

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 47 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY Louisville, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ann Middle Margaret Last BREITENSTEIN		4. DATE OF DEATH Month August Day 1 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-17
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 3 Days 1 Hours 15 Min.	11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred BREITENSTEIN	
14. MOTHER'S MAIDEN NAME Florence SCHOENLAUBE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 401 10 6220		17. INFORMANT Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6-15- 19 60 to 8-1- 19 60 , that (I) (we) last saw the deceased alive on 8-1- 19 60 , and that death occurred at 9:18 PM from the causes and on the date stated above.	
22a. SIGNATURE F. S. Caldwell M.D.		22b. DATE SIGNED 8-2-60	
22c. PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-2-60	
23c. NAME OF CEMETERY OR CREMATORY Cave Hill Cemetery		23d. LOCATION (City, town, or county) (State) Louisville, Kentucky	
24. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home		25a. REC'D BY REGISTRAR Aug 4 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Adams		25c. DATE AUG 4 '60	

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TO HOSPITAL OR ATTENDING PHYSICIAN: Now requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9265

09242

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SAN. & HOSPITAL</u>		d. STREET ADDRESS <u>12513 Feldon St. 1</u>	
3. NAME OF DECEASED (Type or print) <u>Gladys Alice Bromley</u>		4. DATE OF DEATH <u>Aug. 30 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>5-22-14</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>46</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Albert Wiggins</u>		14. MOTHER'S MAIDEN NAME <u>Ina Austin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Wash. San. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Essential</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1 1960</u> to <u>Aug 30 1960</u> that (I) (the) last saw the deceased alive on <u>Aug 30 1960</u> and that death occurred at <u>10:40 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George B Patrick Jr</u>		22b. DATE SIGNED <u>8/30/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>George B Patrick, Jr M.D.</u>		22d. ADDRESS <u>9221 Colesville Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		23b. DATE THEREOF <u>9/3/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WESTMORELAND CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WESTMORELAND, ONEIDA COUNTY, N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>	
ADDRESS <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

00320

CERTIFICATE OF DEATH

1955

(M)

State of New York
County of New York
I, the undersigned, a duly qualified and licensed physician, do hereby certify that
on the 12th day of June, 1955, at the City of New York, in the County of New York,
I attended the last illness of
Mrs. Mary Jane Smith, nee Jones, who died at her residence, 1234 Fifth Avenue, New York, N.Y.,
at the age of 78 years, 6 months, and 15 days, of a disease of the heart, which was
the result of a long-standing arteriosclerosis, and which was not due to any
other cause than the natural process of aging.
The death was not due to any violence, accident, or other external cause, and
the deceased was not suffering from any mental disease or defect at the time of her death.
The death was not due to any contagious or infectious disease, and the deceased
was not suffering from any other disease or defect at the time of her death.
The death was not due to any other cause than the natural process of aging.
The death was not due to any violence, accident, or other external cause, and
the deceased was not suffering from any mental disease or defect at the time of her death.
The death was not due to any contagious or infectious disease, and the deceased
was not suffering from any other disease or defect at the time of her death.
The death was not due to any other cause than the natural process of aging.

Witness my hand and the seal of my office this 12th day of June, 1955.
J. Edgar Smith, M.D.
Physician
The seal of my office is hereunto affixed.
J. Edgar Smith, M.D.
Physician
This certificate is valid for a period of 30 days from the date of its issuance.
J. Edgar Smith, M.D.
Physician

9334

CERTIFICATE OF DEATH

09243

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hosp.				d. STREET ADDRESS 1 RFD # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Louis Last Burdette				4. DATE OF DEATH Month August Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1888	
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72		IF UNDER 24 HRS. Hours 72 Min. 72			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed Farmer- Own Farm				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Burdette				14. MOTHER'S MAIDEN NAME Laura Louis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-40-4716		INFORMANT Hospital records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Peritonitis 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Perforation of Duodenum DUE TO (c) Hypertension Heart Failure - Terminal						INTERVAL BETWEEN ONSET AND DEATH 10 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1935 , 19____, to Aug 8, 1960 , that I last saw the deceased alive on Aug 8, 1960 , and that death occurred at 10:00 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE E. E. Kane				ADDRESS (Street, city or town, state) 9830 Main Street, Damascus, Maryland			
DATE SIGNED 8/9/60							
PHYSICIAN'S NAME (Type) M. M. Boyer, M.D.				Damascus, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 11, 1960		22c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.		22d. LOCATION (City, town, or county) (State) Browningsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR AUG 11 '60	
				24b. REGISTRAR'S SIGNATURE C. E. Kane			

03213

CERTIFICATE OF DEATH

1934



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Items 13, 14 Film G270 9-7-60 et

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hosp.				d. STREET ADDRESS 13 X - 2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Burgess Last Burgess				4. DATE OF DEATH Month August Day 30 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1876	
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min.		IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
INFORMANT Hospital records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephrosclerosis with uremia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary sclerosis with chronic myocardial failure 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 5, 19 60 to August 30, 19 60 that I last saw the deceased alive on August 30, 19 60 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED Arthur S. Kraus							
ACTUAL SIGNATURE C. Whitaker M.D.							
PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D., Clarksville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 9-2-60							
22c. NAME OF CEMETERY OR CREMATORY St. Louis							
22d. LOCATION (City, town, or county) (State) Clarksville, Md							
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md ADDRESS							
24a. REC'D BY REGISTRAR SEP 2 '60							
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 1 of 1. This certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00341

CERTIFICATE OF DEATH

Dec 1941

Dec 1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9336

09245

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 21 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ch evy Chase			
f. STREET ADDRESS 3700 Dunlop St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rob ert Middle R. Last Burklin				4. DATE OF DEATH Month August Day 28 Year 19 60			
5. SEX M ale		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/24/90	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Acting Gov. Fed. Home Loan Board				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
13. FATHER'S NAME George Burklin				14. MOTHER'S MAIDEN NAME Harriett Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT May W. Burklin-3700 Dunlop St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Acidosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Cholelithiasis and Cholecystitis DUE TO (c) Chronic Cholelithiasis				INTERVAL BETWEEN ONSET AND DEATH 1 day 3 weeks 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Azotemia and Bronchopneumonia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D. C.				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Nov. 13 , 19 55 , to August 28 , 19 60 , that (I) (we) last saw the deceased alive on August 28 , 19 60 , and that death occurred at 12P , from the causes and on the date stated above.							
22a. SIGNATURE Robert G. Angle				22b. DATE Aug ust 28, 60			
22c. PHYSICIAN'S NAME (Type) Robert G. Angle				22d. ADDRESS 5009 Del Ray Avenue, Bethesda, M d.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/3/60		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
23d. LOCATION (City, town, or county) Washington, D. C.				23e. (State) Md.		23f. (Country) U. S. A.	
24. FUNERAL DIRECTOR'S SIGNATURE 24e S. H. Hines Co.				24b. ADDRESS 2901-14th St N.W.		25a. REC'D BY REGISTRAR SEP 1 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines				25c. DATE SEP 1 '60			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9299

CERTIFICATE OF DEATH

09246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4007 Bradley Lane</u>		d. STREET ADDRESS <u>4007 Bradley Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Henry</u> Last <u>Burr</u>		4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Webster Mass.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles H. Burr</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Sharpe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Yes</u> 1921 to 1941		16. SOCIAL SECURITY NO. <u>213-38-4257</u>	
17. INFORMANT <u>sister M. Carmen Burr</u> Address <u>same as deceased</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis and Parkinsonism</u> DUE TO (c) <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia - 1 day</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30, 1960</u> , to <u>August 1, 1960</u> , that I last saw the deceased alive on <u>August 1, 1960</u> , and that death occurred at <u>9:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Allen J. O'Neill</u> M.D. <u>8601 old Georgetown Rd</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill M.D. Bethesda 19 MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CERTIFICATE OF DEATH

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PLACE OF DEATH		DATE OF DEATH	
HOME		MAY 18 1921	
CITY		BOSTON	
COUNTY		SUFFOLK	
AGE		SEX	
60		M	
MARRIAGE		SINGLE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR	
[Signature]		[Signature]	
DATE		DATE	
MAY 18 1921		MAY 18 1921	
TIME		TIME	
10:00 AM		10:00 AM	
PLACE OF BURIAL		DATE OF BURIAL	
CATHOLIC CHURCH		MAY 19 1921	
CITY		BOSTON	
COUNTY		SUFFOLK	
AGE		SEX	
60		M	
MARRIAGE		SINGLE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR	
[Signature]		[Signature]	
DATE		DATE	
MAY 18 1921		MAY 18 1921	
TIME		TIME	
10:00 AM		10:00 AM	

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU ONE TO
RECEIVED
MAY 18 1921
BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09247

9337

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Garrett Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10804 Weymouth Street				d. STREET ADDRESS 10804 Weymouth Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) FAITH		First ELIZABETH		Middle BURRISS		Last	
4. DATE OF DEATH Aug. 25 1960		Month		Day		Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/60		9. AGE (In years lost birthday) yrs. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Carl Edmund Burriss				14. MOTHER'S MAIDEN NAME Mary Helen Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Carl Edmund Burriss-father-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 277X Aplasia - resuscitation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Adreno-genital syndrome DUE TO (c) unknown							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/18/60 to 8/25/60 that (I) (we) last saw the deceased alive on 8/22/60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Alfred S. Norton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug. 26, 1960	
22c. PHYSICIAN'S NAME (Type) ALFRED S. NORTON				22d. ADDRESS 4711 Highland Ave., Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/29/60		23c. NAME OF CEMETERY OR CREMATORY Friends Mt. House Cem		23d. LOCATION (City, town, or county) (State) Sandy Spring, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE AUG 30 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CENTRAL OF MARYLAND

9331

MONTGOMERY

MARYLAND

MONTGOMERY

Garrett Park

MONTGOMERY GARRETT PARK

10000 Wisconsin Street

10000 Wisconsin Street

ELIZABETH GARRETT

ELIZABETH

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1/15/70

1/15/70

Female

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MARYLAND

Infant

1 Mary Helen Morris

Carl Edmund Morris

Carl Edmund Morris - father - same 28

Mother

B-

271 Highland Ave., Bethesda, Md.

MARSHALL A. MORRIS

Friends M. House Cem. Sandy Spring, Maryland

2/20/70

Bethesda, Maryland

Robert A. Montgomery

22300

CERTIFICATE OF DEATH

22300

100-10330

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9246

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09249

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,027 Tenbrook Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALFRED Middle R. Last CALHOUN		4. DATE OF DEATH Month AUGUST Day 18 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 25, 1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Capital Transit Co.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRISON M. CALHOUN		14. MOTHER'S MAIDEN NAME VIRGINIA MULLENEAUX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 256-14-7172	
17. INFORMANT Mr. Everett Calhoun, 10,027 Tenbrook Dr.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO (b) (Generalized cerebral metastases) DUE TO (c) 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1957 to Aug. 18, 1960 , that (I) (we) last saw the deceased alive on August 16, 1960 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Belden R. Reap M.D.		22b. DATE SIGNED Aug. 18, 1960	
22c. PHYSICIAN'S NAME (Type) BELDEN R. REAP, M.D.		22d. ADDRESS WHEATON, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/22/60	
23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WAGNER E. PUMPHREY, INC.		25a. REC'D BY REGISTRAR DATE AUG 24 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

03340

03340

CERTIFICATE OF DEATH

DECEASED

50 YRS

10/1/1911

10/1/1911

DECEASED

10/1/1911

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9266

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09250

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Vera</i> Middle Last <i>Capants</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-4-09</i>
9. AGE (In years last birthday) <i>50</i>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>9</i> Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Latvia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Karliss Brazaus</i>		14. MOTHER'S MAIDEN NAME <i>Maria Blum</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-32-7827</i>	
17. INFORMANT <i>W. S. Hosp. Records.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia, Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma lung with metastasis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>8 months.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>February</i> 19 <i>60</i> , to <i>Aug. 13</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>8/13</i> 19 <i>60</i> , and that death occurred at <i>1:30 P.</i> M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Marvin L. Kolkin</i>		22b. DATE SIGNED <i>8/13/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Marvin L. Kolkin</i>		22d. ADDRESS <i>8485 Fenton St., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/16/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rocky Creek</i>		23d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler F.H.-1331 E. Montg. Ave. Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>AUG 17 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

02220

CERTIFICATE OF DEATH

02220



[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

9267

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>3410 Davidson St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Andrew</u> Last <u>Carter</u>				4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-93</u>		9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector, Plumber Sub. Wash. San.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Comm.</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Carter</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Mathias</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>214-03-9155</u>		INFORMANT <u>Washington Sanatorium Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> 332A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Encephalomalacia</u> DUE TO (c) <u>UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> <u>Coronary Thrombosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 7</u> , 19 <u>60</u> to <u>Aug 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>60</u> , and that death occurred at <u>1:55</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Richards</u>		ADDRESS (Street, city or town, state) <u>10,110 Ga. Ave., Silver Spring, Md.</u>					
PHYSICIAN'S NAME (Type) <u>EDWARD J. RICHARDS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOREST OAK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>GAITHERSBURG, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Aug 16 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Caring S. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

9268
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09252

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>DISTRICT of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN & Hosp</u>				d. STREET ADDRESS <u>2800 QUEBEC ST. NW</u>			
3. NAME OF DECEASED (Type or print) <u>Quise Ernest Cassab</u>				4. DATE OF DEATH <u>8-8-60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-17-14</u>	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>FARRIS Cassab</u>				14. MOTHER'S MAIDEN NAME <u>Amelia NACKOUZ</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>237-01-2036</u>			
17. INFORMANT <u>Harvey F. Cassab</u>				Address <u>3605 Seminary Richmond Va.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c) DUE TO <u>Interval between onset and death</u> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8-8-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>8/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Long Island National Cem. Farmingdale, Long Island, N. Y.</u>	
23. FUNERAL DIRECTOR <u>Wm. J. Tickner & Sons - Bethesda Md.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

08522

0508

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9339

09253

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D. C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>		d. STREET ADDRESS <u>Sherraton Park Hotel</u>	
3. NAME OF DECEASED (Type or print) <u>Violet Thompson Chase</u>		4. DATE OF DEATH <u>Aug. 18</u> 19 <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/28/80</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>Thompson</u>		14. MOTHER'S MAIDEN NAME <u>R. Ringgold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Capt. Spencer Smith</u>		Address <u>1525 N. Jefferson Arlington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation.</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis.</u> DUE TO (c) <u>Many years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-1-60</u> to <u>8-18</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Aug 14</u> 19 <u>60</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Reuben Goodman, M.D.</u>		22b. DATE SIGNED <u>Aug 14</u>	
22c. PHYSICIAN'S NAME (Type) <u>REUBEN GOODMAN</u>		22d. ADDRESS <u>746 K. N. W. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/22/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Philadelphia Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kump</u>		25a. REC'D BY REGISTRAR <u>AUG 22 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kump</u>		25c. ADDRESS <u>Arlington Funeral Home 3901 No. Fairfax Dr. Arlington 3, Virginia</u>	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9340

09254

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 30 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last CHEDESTER			4. DATE OF DEATH Month August Day 19 Year 19 60		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-28-93		9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY Auditor		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Louis CHEDESTER		
14. MOTHER'S MAIDEN NAME Adina SNYDER			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Blanche A. CHEDESTER		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal insufficiency, secondary to chronic pyelonephritis.			INTERVAL BETWEEN ONSET AND DEATH YEARS.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-20 19 60 to 8-19 19 60 that (I) (we) last saw the deceased alive on 8-19 19 60 , and that death occurred at 7:25AM from the causes and on the date stated above.					
22a. SIGNATURE Russell Miller Jr. MD			22b. DATE SIGNED 8-19-60		
22c. PHYSICIAN'S NAME (Type) Russell MILLER Jr., LT, MC, USN			22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-22-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron	
23d. LOCATION (City, town, or county) (State) Petersburg, W. Va.		24. FUNERAL DIRECTOR'S SIGNATURE CHEVY CHASE FUNERAL HOME		25a. REC'D BY REGISTRAR DATE AUG 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

(I)

MEDICAL CERTIFICATION

10524

CENTRAL AT OF ORIGIN

8340

(M)

1. Name of the person

1. Name of the person

2. Date of birth

2. Date of birth

3. Place of birth

3. Place of birth

4. Sex

4. Sex

5. Race

5. Race

6. Religion

6. Religion

7. Education

7. Education

8. Occupation

8. Occupation

9. Marital status

9. Marital status

10. Date of entry

10. Date of entry

11. Date of departure

11. Date of departure

12. Date of return

12. Date of return

13. Date of death

13. Date of death

14. Date of burial

14. Date of burial

15. Date of cremation

15. Date of cremation

16. Date of interment

16. Date of interment

17. Date of exhumation

17. Date of exhumation

18. Date of reinterment

18. Date of reinterment

19. Date of removal

19. Date of removal

20. Date of return

20. Date of return

21. Date of departure

21. Date of departure

22. Date of return

22. Date of return

23. Date of departure

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9341

09255

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MD.</u>				c. LENGTH OF STAY IN 1b <u>5 HRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSP.</u>				e. STREET ADDRESS <u>112210 HUNTER'S COURT</u>			
3. NAME OF DECEASED (Type or print) <u>GEORGE ANDREW CLARK</u>				4. DATE OF DEATH <u>AUGUST 27 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 26, 1913</u>	9. AGE (In years lost birthday) <u>47</u> rs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GAS STATION OPER. SELF-EMPLOY.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE HARRY CLARK</u>				14. MOTHER'S MAIDEN NAME <u>KATIE ROTHENBUCHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES U.S. ARMY</u>				16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		17. INFORMANT <u>HELEN CLARK - 12210 HUNTERS COURT</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>441 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MALIGNANT PHASE OF HYPERTENSIVE VASCULAR DISEASE</u> DUE TO (c) <u>As?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive heart disease. Probable renal insufficiency</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12:30 - 2:00 p.m.</u> 19 <u>60</u> , to <u>2:00 p.m.</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>27 Aug.</u> 19 <u>60</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>IRA N. TUBLIN</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/27/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>IRA N. TUBLIN</u>				22d. ADDRESS <u>25 E WAYNE AVE S.S.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/29/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 30 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

DR. BROCHART NOTIFIED

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9342

09256

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOYDS		c. LENGTH OF STAY IN 1b 15 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOYDS		d. STREET ADDRESS R. F. D. # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VICTOR Middle VERSALE Last COLES		4. DATE OF DEATH Month AUGUST Day 26 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/03
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 3 Days 15 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDENER - on an estate		10b. KIND OF BUSINESS OR INDUSTRY GARDENER	
11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FOREST COLES		14. MOTHER'S MAIDEN NAME Unknown NICHOLS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 1929-1931		16. SOCIAL SECURITY NO. 578-34-0257	
17. INFORMANT Mrs. Melva B. Coles, R.F. D. # 1, Boyds, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Arteriosclerotic Heart Disease DUE TO (c) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH Minutes 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1960 to Aug. 26, 1960 that (I) (we) last saw the deceased alive on Aug. 24, 1960, and that death occurred at 2:15 PM, from the causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher		22b. DATE SIGNED Aug. 26, 60	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher		22d. ADDRESS Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/30/60	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE WASNER E. DILLERY, INC. Raymond A. Giska		25a. REC'D BY REGISTRAR SILVER SPRING, MD. AUG 31 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9269

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09257

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington SAN + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Osmond</u> Middle <u>James</u> Last <u>Condon</u>				4. DATE OF DEATH Month <u>8</u> - Day <u>7</u> - Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-27-93</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Serv-National Architectural Metal Bsn.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>			
13. FATHER'S NAME <u>Osmond J. Condon</u>				14. MOTHER'S MAIDEN NAME <u>Udora Schofield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.I.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-34-1626</u>		17. INFORMANT <u>Mrs. Olive M. Condon (Pam at #2)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus Encephalitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>082123</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>7/20/1958</u> to <u>Aug 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>8/6/1960</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. B. Little</u>				22b. DATE SIGNED <u>8/7/60</u>		22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation Aug. 10, 1960</u>				23b. DATE THEREOF <u>Aug. 10, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Griffin Lincoln Crematory Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 264 Carroll St. NW.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10527

OFFICE OF DEATH

10527



TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09258

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 50 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle -- Last COOPER		4. DATE OF DEATH Month AUGUST Day 5 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/87
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM ADAMS		14. MOTHER'S MAIDEN NAME GEORGIANNA MCGRUDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS,		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Hemiplegia DUE TO Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 mo DUE TO (c) 2 mo		INTERVAL BETWEEN ONSET AND DEATH 2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 7/30 p. m. 60		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rockville, MD. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/30 19 60 , to 8/5 19 60 , that (I) (we) last saw the deceased alive on 8/5 19 60 , and that death occurred at 8/5 19 60 , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/60	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,		23d. LOCATION (City, town, or county) (State) Rockville, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surwden - Rockville, MD.		25a. REC'D BY REGISTRAR AUG 10 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

00228

CERTIFICATE OF DEATH

3846



MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
DIVISION OF DEATH REGISTRATION

NAME: JOHN J. HOGAN
AGE: 45 YEARS
SEX: MALE
DATE OF BIRTH: 12-15-1907
PLACE OF BIRTH: NEW YORK
OCCUPATION: LABORER
CAUSE OF DEATH: HEART DISEASE
DATE OF DEATH: 12-15-1952
PLACE OF DEATH: NEW YORK
REGISTRATION NO.: 3846



MADE IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9344

09259

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Great Mills St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills d. STREET ADDRESS Green View Knolls e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle Lynn Last Crafton		4. DATE OF DEATH Month August Day 30 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-60
9. AGE (In years last birthday) 8 yrs.		10. IF UNDER 1 YEAR Months 8 Days 17	11. IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Wiley CRAFTON		14. MOTHER'S MAIDEN NAME Shirley TUGGLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert W. CRAFTON		Address 716 Pickwell Dr. San Antonio, Texas	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROCEPHALUS DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that he (this hospital) attended the deceased from 8-30 19 60 to 8-30 19 60 , that (I) (we) last saw the deceased alive on 8-30 19 60 , and that death occurred at 2:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE Robert V. Rack Lt.		22b. DATE SIGNED 8-30-60	
22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-31-60	
23c. NAME OF CEMETERY OR CREMATORY Chapel Hill Memorial		23d. LOCATION (City, town, or county) (State) San Antonio Texas	
24. FUNERAL DIRECTOR'S SIGNATURE R. E. Pumphrey		25a. REC'D BY REGISTRAR SEP 2 '60	
ADDRESS Beth., Md. 7557 Wisc. Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

9VVVVVVVVVV

05250

CERTIFICATE OF DEATH

05250



John V. Allen
John V. Allen

John V. Allen
John V. Allen

John V. Allen

John V. Allen

John V. Allen

John V. Allen



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

<p align="center">MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 9270 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p>									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 7502 Flower Ave.						
3. NAME OF DECEASED (Type or print) William C Curtis			4. DATE OF DEATH Month Aug. Day 1, Year 1960				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/17/1890		9. AGE (In years last birthday) 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician			10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.			11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dr. Andrew Curtis					14. MOTHER'S MAIDEN NAME Mary Clapp				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>William C. Curtis Jr.</i>		Address <i>8422 Broadhead Drive Spring Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVIEW BETWEEN ON DEATH						
20a. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Frank J. Broschart</i>			EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/1/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF August 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or country) (State) Washington D.C.		
23. FUNERAL DIRECTOR <i>John J. ...</i>			ADDRESS 254 ...		24a. REC'D BY REGISTRAR AUG 3 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>		

09260
Montg

09200

09200



Jan. 1, 1940

10/11/1940

white

male

7.5. 1940

of occupation

Mar. 1940

Dr. Andrew Curtis

Handwritten signature: William Curtis

Continuing Conclusion

09200

Handwritten signature: William Curtis

9345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09261

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pri. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS 9020 Hobart Street			
3. NAME OF DECEASED (Type or print) TwinB Edward First Middle Last				4. DATE OF DEATH August 8 1960 Month Day Year			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 August 1960	
9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn	
11. BIRTHPLACE (State or foreign country) USNH, Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry Charles DAVIS			
14. MOTHER'S MAIDEN NAME Esther Rita CLEMENTS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Harry C. Davis, 9020 Hobart St., Ardmore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Disline Membrane Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) App. 12 hrs.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 8-8-1960 to 8-8-1960 , that (I) (we) last saw the deceased alive on 8-8-1960 , and that death occurred 10:45 PM from the causes and on the date stated above.			
22a. SIGNATURE H. L. Walton				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-9-60	
22c. PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Funeral Home				ADDRESS 4739 Balt. Ave. Hyattsville, Md.		25a. REC'D BY REGISTRAR AUG 15 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris							

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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0345

CERTIFICATE OF DEATH

00761

Name: Harry Charles Davis
 Sex: Male
 Race: White
 Date of Birth: 15 August 1900
 Place of Birth: Urbana, Illinois, U.S.A.
 Date of Death: 15 August 1900
 Place of Death: Urbana, Illinois, U.S.A.
 Cause of Death: Infantile Paralysis
 Physician: Dr. J. C. Davis
 Burial Place: Urbana, Illinois, U.S.A.
 Signature: Harry C. Davis, 2020 Robert St., Urbana, Ill.

I, U.S. Naval Hospital, do hereby certify that the above is a true and correct copy of the original record of the death of the above named person.
 Date: 15 August 1900
 Signature: U.S. Naval Hospital
 Location: Urbana, Illinois, U.S.A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

BALTIMORE, 18

09262

9247

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 10 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 606 Thayer Ave.			d. STREET ADDRESS 1 606 Thayer Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Davis			4. DATE OF DEATH Month August Day 3 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1881		9. AGE (In years last birthday) yrs. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Gen. Construction		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph Davis			14. MOTHER'S MAIDEN NAME Rachel Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-01-8049		INFORMANT Address Emma V. Davis Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Gastric hemorrhage DUE TO (b) Cancer of stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of bladder about 3 years					INTERVAL BETWEEN ONSET AND DEATH 1 day 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 58 , to Aug 3 , 19 60 , that I last saw the deceased alive on Aug 3 , 19 60 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Aug 3-60 DATE SIGNED ACTUAL SIGNATURE John N. Andrews M.D. PHYSICIAN'S NAME (Type) Dr. John N. Andrews 9601 Colesville Rd. Silver Spring Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-60		22c. NAME OF CEMETERY OR CREMATORY Forest Oak	
22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Francis L. Barber			ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE AUG 8 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Knead		

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

9346

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09263

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 9020 Hobart St.					
3. NAME OF DECEASED (Type or print) TwinA Raymond		First		Middle		Last		4. DATE OF DEATH Month Day Year August 9 1960	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 August 1960		9. AGE (In years last birthday) yrs. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USNH, Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry Charles DAVIS		14. MOTHER'S MAIDEN NAME Ester Rita CLEMENTS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Harry C. DAVIS, 9020 Hobart St., Ardmore, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Hyaline membrane disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Prematurity DUE TO App. 12 hrs. (c) App. 12 hrs.		INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-8- 1960 to 8-9- 1960 , that (I) (we) last saw the deceased alive on 8-9-60 19 , and that death occurred at 1:24 AM from the causes and on the date stated above.									
22a. SIGNATURE H. L. Walton		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-9-60					
22c. PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Funeral Home		ADDRESS 4739 Balt. Ave. Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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03803

CENTRAL OF DEATH

03803

W. J. Davis

W. J. Davis

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TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09264

1. PLACE OF DEATH a. COUNTY Montgomery				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 27 Days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				3001.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 4811 Truesdale Ave.							
3. NAME OF DECEASED (Type or print) William Leonard DAVIS				First Middle Last William Leonard DAVIS				4. DATE OF DEATH Month Day Year August 14 1960							
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 August 1906		9. AGE (In years or birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
3. FATHER'S NAME Wilbert DAVIS				14. MOTHER'S MAIDEN NAME Annie FORLIFER											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II Korean 213 01 6278				17. INFORMANT Mrs. Dorothy Louise DAVIS, Same as 2d				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastasis 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the lung DUE TO (c) —												INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-18-1960 to 8-14-1960 , that (I) (we) lost saw the deceased alive on 8-14-1960 , and that death occurred on 2025 M, from the causes and on the date stated above.															
22a. SIGNATURE Robert C. Thomas				M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 8-15-60				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Robert C. THOMAS, LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, M											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug. 18, 1960				23c. NAME OF CEMETERY OR CREMATORY Garden of Faith				23d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE BURGEE, FUNERAL HOME, 3617 Falls Rd., Baltimore, Md.				ADDRESS 3617 Falls Rd., Baltimore, Md.				25a. REC'D BY REGISTRAR AUG 17 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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NAVY DEPARTMENT
WASHINGTON, D.C.

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NAVY DEPARTMENT
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9348

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 16 Film G268 8-10-60 et
CERTIFICATE OF DEATH

09265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY -----	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5017 Upton St., N.W.	
3. NAME OF DECEASED (Type or print) Homer Frank Dawson		4. DATE OF DEATH August 4, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/1887
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Dawson		14. MOTHER'S MAIDEN NAME Arminta Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWI		16. SOCIAL SECURITY NO. 579-50-0034	
17. INFORMANT Mrs. Jessie Dawson		Address 5017 Upton St., N.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertensive cardio-renal disease DUE TO (c) Chronic glomerulonephritis type Arteriolar		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 5 yrs + 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic uremia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 1947 to 8.4. 1960, that I last saw the deceased alive on 8.3. 1960, and that death occurred at 3:00 a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp M.D.		ADDRESS (Street, city or town, state) 4740 Chevy Chase Dr. N.W. DATE SIGNED 8/4/60	
PHYSICIAN'S NAME (Type) Stewart Clapp		Chevy Chase Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/8/60	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		ADDRESS Washington, D. C.	
24a. REC'D BY REGISTRAR DATE AUG 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krand	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS ILLNESS	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09266

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 Hours 35Mi.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland	
3. NAME OF DECEASED (Type or print) First Andrea Middle Lea Last DEVENNEY		4. DATE OF DEATH Month August Day 15 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-57
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. DEVENNEY		14. MOTHER'S MAIDEN NAME Dixie L. MURREY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Dixie L. DEVENNEY, Same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 344-X IMMEDIATE CAUSE (a) Massive hydrocephalus & convulsions DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 1 (this hospital) attended the deceased from 8-15- 1960 , to 8-15- 1960 , that (I) (we) last saw the deceased alive on 8-15- 1960 , and that death occurred at 6:50AM the causes and on the date stated above.			
22a. SIGNATURE H. L. Walton		22b. DATE SIGNED 8-15-60	
22c. PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-23-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY		25a. REC'D BY REGISTRAR DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Fraser			

AUG 22 '60

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DEPARTMENT OF DEATH

1. Name of Deceased: [Illegible]
2. Date of Death: [Illegible]
3. Place of Death: [Illegible]

4. Name of Informant: [Illegible]
5. Address of Informant: [Illegible]
6. Signature of Informant: [Illegible]

7. Name of Physician: [Illegible]
8. Address of Physician: [Illegible]

9. Name of Burial Place: [Illegible]
10. Address of Burial Place: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09267
Reg. Dist. No.

9248

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Maryland</u> d. STREET ADDRESS <u>6105-42nd Place 1862-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Adolph</u> Last <u>Dorr</u>		4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Penter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bladensburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George A. Dorr</u>		14. MOTHER'S MAIDEN NAME <u>Ley Polid, Margaret</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>263-30-8489</u>	
17. INFORMANT <u>Maybelle Dorr Wille T</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u> <u>8 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-20</u> , 19 <u>59</u> , to <u>Aug 28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-2</u> , 19 <u>60</u> , and that death occurred at <u>4:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.D. Baker M.D.</u>		ADDRESS (Street, city or town, state) <u>2513 Brookridge Rd. Adelphi, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R.D. BAKER M.D.</u>		DATE <u>Aug 31 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

0248

<p>NAME OF DECEASED [Illegible]</p>		<p>DATE OF DEATH [Illegible]</p>	
<p>AGE [Illegible]</p>		<p>SEX [Illegible]</p>	
<p>PLACE OF BIRTH [Illegible]</p>		<p>DATE OF BIRTH [Illegible]</p>	
<p>CAUSE OF DEATH [Illegible]</p>		<p>PLACE OF DEATH [Illegible]</p>	
<p>DATE OF INTERMENT [Illegible]</p>		<p>PLACE OF INTERMENT [Illegible]</p>	
<p>SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>SIGNATURE OF REGISTRAR [Illegible]</p>	
<p>DATE OF SIGNATURE [Illegible]</p>		<p>DATE OF SIGNATURE [Illegible]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>District of Columbia</i> COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germantown</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Marylander Nursing Home</i>		d. STREET ADDRESS <i>2310 Ashmead Place, N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>SALLIE</i> Middle <i>DOUTHAT</i> Last <i>DOUTHAT</i>		4. DATE OF DEATH Month <i>August</i> Day <i>1</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 6, 1872</i>
9. AGE (In years lost birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>Virginia</i>	
13. FATHER'S NAME <i>Daniel H. Carr</i>		14. MOTHER'S MAIDEN NAME <i>Sallie Bane</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Clyde B. Douthat</i>	
17. INFORMANT <i>Clyde B. Douthat</i>		Address <i>2310 Ashmead Pl., NW, Wash., DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>10 years</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 10, 1958</i> to <i>August 1, 1960</i> that I last saw the deceased alive on <i>July 26, 1960</i> , and that death occurred at <i>11:35 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James P. Kerr</i>		ADDRESS (Street, city or town, state) <i>Damascus, Md.</i>	
PHYSICIAN'S NAME (Type) <i>James P. Kerr</i>		DATE SIGNED <i>8/2/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5 August 60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ivy Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Alexandria, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. B. Mountcastle</i> ADDRESS <i>Cunningham Funeral Home Inc. Box 65, Alex., Va.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 5 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanes</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 of 4.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9271

09269

Item 7 Film 6270 9-6-60 et

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 8013 14th Avenue	
3. NAME OF DECEASED (Type or print) First Walter Middle (None) Last Doxon		4. DATE OF DEATH Month 8 Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1896
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Treasury Dept	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Walter Doxon	
14. MOTHER'S MAIDEN NAME Martha		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War I	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Washington Sanitarium and Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Myocardial Infarction, acute DUE TO (c) Arteriosclerosis & Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 day 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity; Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 8/13/60 to 8/18/60 (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/13/60 to 8/18/60 , that (I) (we) last saw the deceased alive on 8/18/60 and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE David Goldenberg		22b. DATE SIGNED 8/18/60	
22c. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG		22d. ADDRESS 10620 GEORGIA, SIL SPR, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-22-1960	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		23d. LOCATION (City, town, or county) Arlington, Va. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley's Son Wash. D. C.		25a. REC'D BY REGISTRAR DAUG 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

00380

CENTRAL AIR OF DEATH

8511

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9351

CERTIFICATE OF DEATH

09270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle Josephine Last Duke		4. DATE OF DEATH Month August Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1904
9. AGE (In years, lost birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BURMA		12. CITIZEN OF WHAT COUNTRY? GREAT BRITAIN	
13. FATHER'S NAME E. P. STONE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT (DAUGHTER) Address MRS. CHRISTOPHER 4607 CHESTENHAM BETHESDA			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, massive DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO UNKNOWN (c) Diabetes mellitus DUE TO KNOWN 18mo.		INTERVAL BETWEEN ONSET AND DEATH 11-Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETIC NEUROPATHY, NEPHROPATHY, ADVANCED		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1959 to THE PRESENT , that I last saw the deceased alive on JULY 18, 1960 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) WASHINGTON D.C. DATE SIGNED WASHINGTON 15, D.C.			
ACTUAL SIGNATURE Edward W. Youngblood		PHYSICIAN'S NAME (Type) WASHINGTON 15, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/60	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR AUG 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

00370

CERTIFICATE OF DEATH

8854

RECEIVED
JAN 10 1964
FBI - NEW YORK

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10742

RECEIVED
JAN 10 1964
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9352

CERTIFICATE OF DEATH

09271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 37 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clara R.		4. DATE OF DEATH Month August Day 11 Year 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/23/88	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 2 Days 14 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Jacob Ronnold		14. MOTHER'S MAIDEN NAME Caroline Olson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Daughter (Irene Dysland)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, chronic 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) possible underlying malignancy DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 Months 2 Mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 , to 8/11 , 19 60 , that I last saw the deceased alive on 8/10 , 19 60 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10011 Georgia Ave Silver Spring Md DATE SIGNED 8/11/60 ACTUAL SIGNATURE H.N. Stout M.D. PHYSICIAN'S NAME (Type) H.N. STOUT 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 8/15/60 22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND 23. FUNERAL DIRECTOR'S SIGNATURE WANNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond E. Ziska 24a. REC'D BY REGISTRAR DATE AUG 16 '60 24b. REGISTRAR'S SIGNATURE Arthur L. House			

1937

CERTIFICATE OF DEATH

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[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

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TO FURNISH OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9353

9353

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09272

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY Canal Zone c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Davis d. STREET ADDRESS U.S.A.R. C.A.I.B. School Quarters #38 e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Edgar			4. DATE OF DEATH Month August Day 18 Year 1960				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1921		9. AGE (In years lost birthday) 38 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Secretarial		11. BIRTHPLACE (State or foreign country) Ohio			
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William J. Evans			14. MOTHER'S MAIDEN NAME Laura Kreighbaum				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 380-14-6940		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 411X (b) Rheumatic heart disease DUE TO (c) Aortic stenosis and insufficiency					INTERVAL BETWEEN ONSET AND DEATH 1 hour		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) attended attended the deceased from August 14, 1960 to August 18, 1960 , that (I) was last saw the deceased alive on August 18, 1960 , and that death occurred at 12:34 PM from the causes and on the date stated above.							
22a. SIGNATURE Benson R. Wilcox		22b. DATE SIGNED 8/19/60		22c. PHYSICIAN'S NAME (Type) Benson R. Wilcox, M.D.			
22d. ADDRESS The Clinical Center		22e. ADDRESS National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/23/60		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.			
23d. LOCATION (City, town, or county) Arlington, Virginia		23e. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR AUG 23 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. Kneiss							

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CERTIFICATE OF DEATH

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Age

Sex

Color

Birth

Place

Occupation

Education

Marital Status

Religion

Usual Residence

Place of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Manner of Death

Signature of Physician

Signature of Registrar

Age

Sex

Color

Birth

Place

Occupation

Education

Marital Status

Religion

Usual Residence

Place of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Manner of Death

Signature of Physician

Signature of Registrar

Age

Sex

Color

Birth

Place

Occupation

Education

Marital Status

Religion

Usual Residence

Place of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Manner of Death

Signature of Physician

Signature of Registrar

Age

Sex

Color

Birth

Place

Occupation

Education

Marital Status

Religion

Usual Residence

Place of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Manner of Death

Signature of Physician

Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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9354
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09273

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY Bessemer c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bt. #4, Box 26234 S.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Selma		First Selma		Middle (None)		Last Ellis		4. DATE OF DEATH Month August Day 31 Year 1960							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1916		9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Alabama				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME (First name unknown) Ellis						14. MOTHER'S MAIDEN NAME Hattie Thorention									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 420-09-0405				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse 202. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Malignant Lymphoma DUE TO (c) Bilateral pneumonia INTERVAL BETWEEN ONSET AND DEATH 45 minutes 10 months															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		(County) Montgomery		(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from August 20, 1960 to August 31, 1960 , that (I) (we) last saw the deceased alive on August 31, 1960 , and that death occurred at 5:25 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Sheldon M. Wolff, M.D.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 9/1/60							
22c. PHYSICIAN'S NAME (Type) Sheldon M. Wolff, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) 9-3-60				23b. DATE THEREOF 9-3-60				23c. NAME OF CEMETERY OR CREMATORY Bessemer				23d. LOCATION (City, town, or county) Ala.			
24. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home, Inc.						ADDRESS Frazier's Funeral Home, Inc.						25a. REC'D BY REGISTRAR DATE SEP 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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Post Office, Bethesda, Md.
The Clinical Center, Bethesda, Md.

December 22, 1962

30-9-1009 The Clinical Center, Bethesda, Md.

Post Office, Bethesda, Md.
The Clinical Center, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9272

09275

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>State Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakoma Park</i>		c. LENGTH OF STAY IN 1b <i>22 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. San & Hospital</i>				d. STREET ADDRESS <i>641 Sligo Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MAUDE</i> Middle <i>MAUDE</i> Last <i>JARIS</i> <i>Lucy MAUDE JARIS</i>				4. DATE OF DEATH Month <i>8</i> Day <i>2</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-18-76</i>		9. AGE (In years lost birthday) yrs. <i>83</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own-home</i>		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>CHALMERS SEDGWICK</i>				14. MOTHER'S MAIDEN NAME <i>VIRGINIA THOMPSON</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Hospital Record.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>493 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Hemorrhage with complete coma July 17-1960</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 16, 1960</i> to <i>Aug 2, 1960</i> , that (I) (we) last saw the deceased alive on <i>Aug 2, 1960</i> , and that death occurred at <i>10:45 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>John N. Andrews</i>				22b. DATE SIGNED <i>Aug 2-1960</i>		22c. PHYSICIAN'S NAME (Type) <i>John N. Andrews</i>	
22d. ADDRESS <i>9601 Colasville Rd Silver Spring Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. & BURIAL 8/4/60</i>		23b. DATE THEREOF <i>8/4/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GREENWOOD CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>WHEELING WY VIRGINIA</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Ziska</i>				ADDRESS <i>SILVER SPRING, MD.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 5 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

03275

CERTIFICATE OF DEATH

03275

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words are difficult to decipher but appear to include:]

... of ...
... born ...
... died ...
... cause of death ...
... signed ...
... registrar ...

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5060 River Rd.			d. STREET ADDRESS 222 E Street, N. W.		
3. NAME OF DECEASED (Type or print) ADOLPHUS FARMER			4. DATE OF DEATH Month Aug. Day 30, Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1897		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY Metropolitan Oil Co.		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME George Farmer			14. MOTHER'S MAIDEN NAME Mary Bealor		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-14-9083		17. INFORMANT Son Adolphus Farmer, Jr. Address 1408 N. Frederick St. Arlington, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington D.C.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Aug. 30, 1960	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-2-60		22c. NAME OF CEMETERY OR CREMATORY Rock Creek	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		ADDRESS		24a. REC'D BY REGISTRAR SEP 2 '60	
				24b. REGISTRAR'S SIGNATURE John S. House	

MEDICAL CERTIFICATION

STATE OF
NEW YORK



OFFICE OF THE
ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4.
may be retained by the hospital or attending physician.
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9249
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
09277

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b Since 1951			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,133 GREENOCK ROAD				d. STREET ADDRESS 10,133 GREENOCK ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CONTEE STANSBURY FICKLEN				4. DATE OF DEATH Month Day Year AUGUST 8 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/30/84	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Banking				10b. KIND OF BUSINESS OR INDUSTRY Trust Co.		11. BIRTHPLACE (State or foreign country) Falmouth, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM FITZHUGH FICKLEN				14. MOTHER'S MAIDEN NAME JULIA BELLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 577-28-1345		17. INFORMANT Mrs. Sarah T. Ficklen, 10,133 Greenock Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 962X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Multiple post-surgical adhesions DUE TO (c) Hemiplegia due to fractured skull PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cysto-pyelitis				INTERVAL BETWEEN ONSET AND DEATH 2 days 55 years 1952 (approx.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 1958 to 8-8-60 that (I) (we) last saw the deceased alive on 8-7-1960, and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Jason Geiger				22b. DATE SIGNED 8-8-60			
22c. PHYSICIAN'S NAME (Type) JASON GEIGER				22d. ADDRESS 931 PERSHING DRIVE, SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8/11/60		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	
23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.							
24. FUNERAL DIRECTOR'S SIGNATURE WAGNER E. PIMPHREY, INC. Raymond D. Ziska				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE AUG 12 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

15520

CERTIFICATE OF DEATH

15520

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9357

CERTIFICATE OF DEATH

09278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle T. Last Fink				4. DATE OF DEATH Month Aug. Day 18 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/69	
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 90 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) Reading, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME EPHRAIM FINK				14. MOTHER'S MAIDEN NAME CAROLINE TEXTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Branchopneumonia (c) Gangrene of left foot							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1959 to 8/18 , 19 60 that I last saw the deceased alive on 8/17/60 and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8166 Maple Ridge Rd, Bethesda, Md DATE SIGNED 8/18/60							
ACTUAL SIGNATURE W. Joyce M.D. 8166 Maple Ridge Rd, Bethesda, Md				PHYSICIAN'S NAME (Type) William T. Joyce 8206 Maple Ridge Ave. Bethesda, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 8-20-60		22c. NAME OF CEMETERY OR CREMATORY LEE'S CREMATORY		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. L... ADDRESS 3004 1st St NE				24a. REC'D BY REGISTRAR DATE AUG 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10378

NOTICE OF CREDIT

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(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G269 8-22-60 et

9358

CERTIFICATE OF DEATH

09279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Pratt c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 123 d. STREET ADDRESS Box 123 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Alfred Andy Fleming				4. DATE OF DEATH Month Day Year August 16 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1906	
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Fleming				14. MOTHER'S MAIDEN NAME Pheeba Keel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 233-12-4742		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO 421.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Ventricular failure DUE TO (c) Calcific aortic stenosis						INTERVAL BETWEEN ONSET AND DEATH 1 hour years	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 14, 1960 , to August 16, 1960 , that I last saw the deceased alive on August 16, 1960 , and that death occurred at 3:32 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8/17/60							
ACTUAL SIGNATURE Joseph W. Gilbert PHYSICIAN'S NAME (Type) Joseph W. Gilbert, M.D.				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) removal		22b. DATE THEREOF 8/17/60		22c. NAME OF CEMETERY OR CREMATORY Highlawn Mem.Pk.Com.		22d. LOCATION (City, town, or county) Oak Hill, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. 2901 14th St. N.W.				ADDRESS Wash., D.C.		24a. REC'D BY REGISTRAR DATE AUG 18 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9359

09280

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 3205 Queenstown Drive		
3. NAME OF DECEASED (Type or print) First Henry Middle Collins Last Fox, Jr.			4. DATE OF DEATH Month August Day 19 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1959		9. AGE (In years last birthday) yrs. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME Henry C. Fox, Sr.			14. MOTHER'S MAIDEN NAME Laurelle C. Bois Vert		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphatic Leukemia DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 days 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 16, 19 60 , to August 19, 19 60 , that I last saw the deceased alive on August 19, 19 60 , and that death occurred at 7:10 P. M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE R. E. Rieselbach			ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-20-60		
PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.			National Institutes of Health Bethesda 14, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/60	22c. NAME OF CEMETERY OR CREMATION Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE AUG 25 1960		
			24b. REGISTRAR'S SIGNATURE <i>William L. Kinn</i>		

CERTIFICATE OF DEATH

1920

Name of Deceased		Age		Sex		Race		Marital Status	
John Doe		45		Male		White		Married	
Date of Death		Place of Death		Cause of Death		Disease or Injury		Occupation	
Jan 15, 1920		Boston, Mass.		Heart Disease		Myocardial Infarction		Teacher	
Time of Death		Physician		Hospital		Burial Place		Funeral Home	
10:30 AM		Dr. J. Smith		St. Mary's		Catholic Cemetery		Doe & Sons	
Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Funeral Home		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issue		Cause of Death		Disease or Injury		Occupation	
Jan 16, 1920		Boston, Mass.		Heart Disease		Myocardial Infarction		Teacher	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9360
CERTIFICATE OF DEATH

09281

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 11 hrs 45 mins. 16 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 152 Colony Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) INFANT First GIRL Middle FOY Last 4. DATE OF DEATH AUGUST 15 1960 Month 15 Day 19 Year 60		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Aug. 15, 1960 9. AGE (In years lost birthday) yrs. 11 Months 11 Days 45 Mins. 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT 10b. KIND OF BUSINESS OR INDUSTRY NONE 11. BIRTHPLACE (State or foreign country) BETHESDA, MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.		3. FATHER'S NAME WILLIAM J. FOY 14. MOTHER'S MAIDEN NAME ELIZABETH ANN MESS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. none 17. INFORMANT Mr. William J. Foy, 152 Colony Road Address Silver Spring, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO 11 hrs 45 min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO 11 hrs 45 min. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.	
22a. SIGNATURE Herbert H. Diamond M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) HERBERT H. DIAMOND 22d. ADDRESS 911 SILVER SPRING AVE., SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 8/17/60 23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY 23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND		24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Silver Spring, Md. ADDRESS 2074-82XV0 25a. REC'D BY REGISTRAR AUG 18 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL CENTER FOR VITAL STATISTICS

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DATE OF DEATH

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31 October 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

9250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09282

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b since 11/21/59 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ALTHEA-WOODLAND NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 814 ROWEN ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle ARTH Last FRECH		4. DATE OF DEATH Month AUG. Day 17 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/78
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Arth		14. MOTHER'S MAIDEN NAME Katherine Adam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Marie F. Hopkins, 814 Rowen Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unemia DUE TO (c) Nephrosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 1 day 4 week est. 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1958 to August 1960 , that (I) (we) last saw the deceased alive on August 17, 1960 and that death occurred at 11:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Patten		22b. DATE SIGNED 8/19/60	
22c. PHYSICIAN'S NAME (Type) RALPH F. PATTEN		22d. ADDRESS 8641-Colesville Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		23b. DATE THEREOF 8/20/60	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		25a. REC'D BY REGISTRAR DATE AUG 22 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9361

CERTIFICATE OF DEATH

09283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pro Geo</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md</u>		c. LENGTH OF STAY IN <u>1 yr 7 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg, Md</u>		16402	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Philomena Rest Home</u>				d. STREET ADDRESS <u>4207 - Edmonston Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>GANS</u> Last <u>GANS</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 6 - 1879</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Fitzgillians</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Scanlon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Helin Bowen Bladensburg, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1, 1959</u> to <u>Aug 10, 1960</u> , that I last saw the deceased alive on <u>8-5-</u> <u>1960</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry J Kichen</u> M.D.				ADDRESS (Street, city or town, state) <u>Wheaton Md</u>		DATE SIGNED <u>Aug 10 - 1960</u>	
PHYSICIAN'S NAME (Type) <u>Harry J Kichen</u>				Wheaton Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Anns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Eusebio Sons of Yattville Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

9305
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09284

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>J.</u> Last <u>GATLEY</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-70</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. A. GATLEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY G. Goodrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-22-4950</u>	
17. INFORMANT <u>Mrs. Lester Twigg-daughter-same 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 8/20</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8/18</u> , 19 <u>60</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul Cantor</u>		22b. DATE SIGNED <u>8/20/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. PAUL CANTOR</u>		22d. ADDRESS <u>4709 Mont. Lane, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/24/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Aug 23 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>	

12001

CERTIFICATE OF DEATH

12001

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Robert A. Burdette, Bethesda, Maryland

6/25/60

Local Death Certificate - Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9362

Items 12, 10c Film G271 9-15-60 et

CERTIFICATE OF DEATH

09285

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 3744 Grant Street, N.E.	
3. NAME OF DECEASED (Type or print) First Delores Middle (none) Last Gibbs		4. DATE OF DEATH Month August Day 31 Year 19 60	
5. SEX Fem ale	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 23, 1934
9. AGE (In years lost birthday) 25 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Assistant		10b. KIND OF BUSINESS OR INDUSTRY None (Baby Sitter)	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alonzo Gibbs		14. MOTHER'S MAIDEN NAME Pearl Norris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMANT The Medical Record, Center, NIH, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal insufficiency DUE TO Diabetic glomerulosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) Diabetes mellitus	
INTERVAL BETWEEN ONSET AND DEATH 5 years		INTERVAL BETWEEN ONSET AND DEATH 5 years	
INTERVAL BETWEEN ONSET AND DEATH 16 years		INTERVAL BETWEEN ONSET AND DEATH 16 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from July 20, 1960 to August 31, 1960 that (he) (we) last saw the deceased alive on August 31, 1960 , and that death occurred at 10:05 AM on the causes and on the date stated above.			
22a. SIGNATURE Ira Pastan		22b. DATE SIGNED 8/31/60	
22c. PHYSICIAN'S NAME (Type) Ira H. Pastan, M.D.		22d. ADDRESS The Clinical Center, NIH, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, — REMOVAL (Specify) 9/5/60		23b. DATE THEREOF 9/5/60	
23c. NAME OF CEMETERY OR CREMATORY Natl. Harmony		23d. LOCATION (City, town, or county) (State) Beltsville P.G. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Blum		25a. REC'D BY REGISTRAR SEP 6 '60	
ADDRESS 3011 12th St. N.E., Washington D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	



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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09286

9363

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>4740 Bradley Blvd.</i>	
3. NAME OF DECEASED (Type or print) <i>Mamie Cordelia Gilliss</i>		4. DATE OF DEATH <i>Aug. 23 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 21-1881</i>
9. AGE (In years lost birthday) <i>78</i> yrs.		10. AGE (In years lost birthday) <i>78</i> yrs.	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Arthur DeLashmett</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-03-2116</i>	
17. INFORMANT <i>Mamie Alberta Silance Wright</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic hypertensive cardiovascular disease 10 yrs</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>arterial nephrosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8-20 1960</i> to <i>8-23-1960</i> , that (I) (we) last saw the deceased alive on <i>8-23-1960</i> and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>Stephen W. DeJter</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>8-24-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>STEPHEN W. DEJTER, M.D.</i>		22d. ADDRESS <i>6719 WILSON LANE, BETHESDA 14, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/26/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Cookesville, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i> ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>AUG 25 '60</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1883



COMMONWEALTH OF MASSACHUSETTS

1883

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STEPHEN W. DEER, Clerk of the Court, Boston, Mass.

State of Massachusetts, County of Suffolk, City of Boston.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9364

09287

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 19 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS Rt. 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HARRY Middle AUGUSTA Last GLOYD				4. DATE OF DEATH Month AUGUST Day 1 Year 1960							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 1886		9. AGE (In years lost birthday) 74 yrs. IF UNDER 1 YEAR: Months 1 Days 1 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALEXANDER GLOYD				14. MOTHER'S MAIDEN NAME FANNIE CLEMENTS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS 1 YEAR										INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 11, 1960, to July 9-1, 1960, that (I) (we) last saw the deceased alive on 7-30-1960, and that death occurred at 6 AM, from the causes and on the date stated above.											
22a. SIGNATURE <i>Frank J. Broschart</i> 22c. PHYSICIAN'S NAME (Type) FRANK J. BROSCART, M. D.						22b. DATE SIGNED 8/1/60 M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS GAITHERSBURG, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8-3-60		23c. NAME OF CEMETERY OR CREMATORY St. Rose		23d. LOCATION (City, town, or county) (State) Gaithersburg, Md			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kneass</i> 24b. ADDRESS						25a. REC'D BY REGISTRAR DATE AUG 3 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>			

CERTIFICATE OF DEATH

MAINTAINING THE RECORDS OF DEATHS

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9365

CERTIFICATE OF DEATH

09288
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1811 ARCOLA AVENUE		d. STREET ADDRESS 1811 ARCOLA AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NORMAN Middle Last GODA		4. DATE OF DEATH Month AUGUST Day 17 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 12, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY POLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERBERT GODA		14. MOTHER'S MAIDEN NAME HANNAH FRANK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-46-7987	
17. INFORMANT HERBERT L. GODA, 3210 PAULINE DR., CH. CH., MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary myocardial infarction due to chronic coronary artery insufficiency - due to arterio-sclerosis DUE TO (b) 14 yrs. DUE TO (c) Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 , 19 60 to Aug 17 , 19 60 that I last saw the deceased alive on Aug 16 , 19 60 , and that death occurred at 10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Saul Holtzman		ADDRESS (Street, city or town, state) 900 17th St. N.W. Wash. D.C.	
PHYSICIAN'S NAME (Type) Saul Holtzman		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-18-60	
22c. NAME OF CEMETERY OR CREMATORY B'NAI ISRAEL CEMETERY		22d. LOCATION (City, town, or county) (State) OXON HILL, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS - 3501-14th St. N.W.		24a. REC'D BY REGISTRAR DATE AUG 19 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9366

09289

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 hrs. 55 min.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boys, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS Box 270		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rennis First Middle Last E. Graham		4. DATE OF DEATH Month Aug. Day 22 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1958	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. FATHER'S NAME Rennis E. Graham		13. MOTHER'S MAIDEN NAME Alene Breeden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Rennis E. Graham/ Father Address As 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatal hemorrhage DUE TO (b) Hemophilia Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 6 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from birth 19 58 to 8/22/60 19 60 , that (I) (we) last saw the deceased alive on 8/22/60 and that death occurred at 8:22 M, from the causes and on the date stated above.					
22a. SIGNATURE Paul D. Cantor		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Paul D. Cantor		22d. ADDRESS 4709 Montgomery Lane. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-25-60		23c. NAME OF CEMETERY OR CREMATORY Germantown Baptist Church	
23d. LOCATION (City, town, or county) Germantown		(State) Md			
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		ADDRESS Gaithersburg, Md.		25a. REC'D BY REGISTRAR DATE AUG 24 '60	
				25b. REGISTRAR'S SIGNATURE C. E. K...	

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MINISTRY OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9367
09290
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 27 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9209 Cedercrest e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Marie Middle Adelaide Last HAMILTON		4. DATE OF DEATH Month August Day 10 Year 1960				
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-95	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 10 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles GALLASSERO			14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Navy Records Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 years					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, moderately advanced					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-14- 1960 to 8-10 1960 , that (I) (we) last saw the deceased alive on 8-10- 1960 , and that death occurred at 11:55 PM from the causes and on the date stated above.						
22a. SIGNATURE F. S. Caldwell		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-11-60		
22c. PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-13-60		23c. NAME OF CEMETERY OR CREMATORY Catholic		23d. LOCATION (City, town, or county) (State) Ottumwa, Iowa
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS 1557 Wisc. Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR DATE AUG 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline

00300

CERTIFICATE OF DEATH

00300



U.S. Naval Hospital
Hawthorne (Hawthorne)
E. Day
Baltimore
M. J. J. J.
U.S. Naval Hospital
Hawthorne (Hawthorne)
E. Day
Baltimore
M. J. J. J.
U.S. Naval Hospital
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M. J. J. J.



U.S. Naval Hospital
Hawthorne (Hawthorne)
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Baltimore
M. J. J. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: Now requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

9273

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09291

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <u>XXXXXX</u> b. COUNTY <u>XXXXXX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>XXXXXX</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium</u>				d. STREET ADDRESS <u>6640 32nd St., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Lake Harveycutter</u>				4. DATE OF DEATH <u>8 - 8 - 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-79</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gov't. worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William B. Harveycutter</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Lake Wash. DC</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>XXXXXX</u> Mrs. Doris Masters, 6640 32nd St., N.W.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, LEFT BREAST, RESECTED 1957</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>170X</u> DUE TO <u>METASTASIS, SPINE, DUE TO A, ABOVE</u> <u>BRONCHITIS PNEUMONIA</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS.</u> <u>MONTHS</u> <u>2 DAYS.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June 8, 1960</u> to <u>Aug 8, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 8, 1960</u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>George L. Ball</u>				22b. DATE SIGNED <u>Aug 9 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				22d. ADDRESS <u>10630 Leroy Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>8/11/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>AUG 12 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

MEDICAL CERTIFICATION

1

8533

DEPARTMENT OF HEALTH

10580

1

2

DEPARTMENT OF HEALTH

10580

8533

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9368

CERTIFICATE OF DEATH

09292

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKEVILLE d. STREET ADDRESS Box 131 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EBENEZER Middle WANZER Last HAVILAND		4. DATE OF DEATH Month AUGUST Day 23 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 8 Days 7	11. IF UNDER 24 HRS. Hours 7 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MERRITT M. HAVILAND		14. MOTHER'S MAIDEN NAME LYDIA HAVILAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Nephrosclerosis DUE TO (c) 6 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Bronchopneumonia (terminal)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 14 1960 to Aug. 23 1960 that (I) (we) last saw the deceased alive on Aug. 22 1960 , and that death occurred at 42 M. from the causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker, B.D.		22b. DATE SIGNED 8/23/60	
22c. PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.		22d. ADDRESS CLARKSVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF AUG. 23-60	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Prince George Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber Laytonville Md.		25a. REC'D BY REGISTRAR AUG 25 60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1938



DECEASED

DATE

PLACE

AGE

RESIDENCE

CAUSE

REPORTED BY

DATE

PLACE

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PLACE

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DATE

PLACE



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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9369

CERTIFICATE OF DEATH

09293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove		c. LENGTH OF STAY IN 1b 1Yr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove d. STREET ADDRESS 405 Sixth Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Berdona Middle Smith Last Healy		4. DATE OF DEATH Month Aug Day 1st Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 13-1886
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 8 Days 18 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Bradford, Pa.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Alton Smith		14. MOTHER'S MAIDEN NAME Bell Kinney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
INFORMANT Norman G. Healey. Washington Grove, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Bronchial Asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma INTERVAL BETWEEN ONSET AND DEATH Minutes 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to Aug. 1, 1960 that I last saw the deceased alive on July 10, 1960 , and that death occurred at 1:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 Russell Ave. Gaithersburg, Md. DATE SIGNED 8-2-60			
ACTUAL SIGNATURE Jack Schumacher		PHYSICIAN'S NAME (Type) Jack Schumacher Gaithersburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-4-60	
22c. NAME OF CEMETERY OR CREMATORY Forest Lawn		22d. LOCATION (City, town, or county) (State) Portland. NY.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE AUG 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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Harman G. Woolley, Washington, D.C.

After the first 1000 copies of the book were distributed, the following were distributed to the following:

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James O. Watson, Washington, D.C.

James O. Watson, Washington, D.C.

James O. Watson, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

1
9370
MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09294

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 4101 Glenrose St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Abner Middle F. Last Hill		4. DATE OF DEATH Month Aug. Day 4, Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1910
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 8 Days 22	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Maki Hill		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 2		16. SOCIAL SECURITY NO. 017-18-4795	
17. INFORMANT Ruth G. Hill-wife-same 2d		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis (c) 		INTERVAL BETWEEN ONSET AND DEATH 4 hours Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 3, 1960 to Aug 4, 1960 , that (I) (we) lost the deceased alive on Aug 4, 1960 , and that death occurred at 4 A.M. from the causes and on the date stated above.			
22a. SIGNATURE George Sharpe		22b. DATE SIGNED Aug 4 1960	
22c. PHYSICIAN'S NAME (Type) George Sharpe		22d. ADDRESS 10511 Summit Ave Kensington, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/60	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE AUG 8 '60	
25b. REGISTRAR'S SIGNATURE Carlton S. Thomas			

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CERTIFICATE OF DEATH

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DEPARTMENT OF HEALTH

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Nov. 15, 1910

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 41 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9251
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09295

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 23 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9625 Mt. Pisgah Road		e. STREET ADDRESS 9625 Mt. Pisgah Road	
3. NAME OF DECEASED (Type or print) First MELISSA Middle RUSSELL Last HILL		4. DATE OF DEATH Month AUG. Day 13 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/06
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Joint Council Educational TV	
11. BIRTHPLACE (State or foreign country) BRYSON CITY, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES A. RUSSELL		14. MOTHER'S MAIDEN NAME HATTIE JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. yes	
17. INFORMANT MR. WILLIAM O. HILL, 9625 Mt. Pisgah Rd., Silver Spring, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bowel 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 5, 1958 to Aug 13, 1960 that (I) (we) last saw the deceased alive on Aug 11, 1960 and that death occurred 4:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Philip E. Jones		22b. DATE SIGNED 8/13/60	
22c. PHYSICIAN'S NAME (Type) Philip E. Jones		22d. ADDRESS 918 Ellsworth Drive Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/16/60	
23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WADNER E. PUMPHREY, INC.		25a. REC'D BY REGISTRAR DATE AUG 18 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

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CENTRAL BANK

1880



UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9371
09296
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 15 hrs. 50 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last William Charles Holston				Month Day Year August 28 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 27, 1960	
9. AGE (In years last birthday) 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Estel Holston				14. MOTHER'S MAIDEN NAME Doris Elaine Gregg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stelectasis DUE TO 760.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Prematurity (3 Mos. 1 lb 15 oz) DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 16 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sandy Spring, Maryland				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/28/60 to 8/28 1960, that (I) (we) last saw the deceased alive on 8/28/1960 , and that death occurred at 6 A.M. from the causes and on the date stated above.							
22a. SIGNATURE A.D. Bonifant				22b. DATE SIGNED 8/28/60			
22c. PHYSICIAN'S NAME (Type) A.D. Bonifant, M.D.				22d. ADDRESS Sandy Spring, Maryland			
23a. BURIAL, CREMATION, REBURY (Specify) Burial		23b. DATE THEREOF Aug 30 1960		23c. NAME OF CEMETERY OR CREMATORY Burtonsville		23d. LOCATION (City, town, or county) (State) Burtonsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis X Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 31 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

2073 321XV0

1931

CERTIFICATE OF DEATH

1930

County of _____ State of _____
I, _____, Registrar of the County of _____, do hereby certify that _____
born _____ died _____ at _____
Cause of death _____
Signed and sealed _____
Registrar of the County of _____



Witness my hand and seal this _____ day of _____, 1930.
_____ Registrar of the County of _____
County of _____ State of _____

9372

Item 9 Film 209 8-17-60 et

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09297

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE BETTISH VICE CONSULATE b. COUNTY SANTIAGO, CUBA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRITISH EMBASSY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Neil Middle (n) Last HONE		4. DATE OF DEATH Month August Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-84
9. AGE (In years last birthday) 74 1/2 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 45 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) British Vice Consul		10b. KIND OF BUSINESS OR INDUSTRY ENGLAND	
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? ENGLAND	
13. FATHER'S NAME Daniel HONE		14. MOTHER'S MAIDEN NAME Ester ELLIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Metastasis DUE TO Adenocarcinoma, Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 154-X DUE TO (c) 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostatic Hypertrophy, Pneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-9- 1960 to 8-10- 1960 , that (I) (we) last saw the deceased alive on 8-10- 1960 , and that death occurred at 2:00PM from the causes and on the date stated above.			
22a. SIGNATURE Helianth E Akers M.D.		22b. DATE SIGNED 8-11-60	
22c. PHYSICIAN'S NAME (Type) m R. E. AKERS, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-15-60	
23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville Maryland	
24. FUNERAL DIRECTOR'S NAME (Type) R. A. PUMPHREY, 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR AUG 15 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Hume			



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252-31

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9373 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09298

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>R. 9,</u>			
	b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>3 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville 1655-2</u>		d. STREET ADDRESS <u>7302 Ryer Rd.</u>	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Clinical Center N.I.H</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
	3. NAME OF DECEASED (Type or print) <u>William Scott Houser</u>		First Middle Last		4. DATE OF DEATH <u>Aug 27 1960</u>		Day Year	
	5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14 - 1958</u>	9. AGE (In year last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>20</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
	13. FATHER'S NAME <u>Roger com Houser</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Hullinger</u>			
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Harv Record</u>			
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> <u>903.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>C.A. left testicle</u> (c) <u>Stempled + struck head against table in Hoof room</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.A. left testicle</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stempled + struck head against table in Hoof room</u>						
20c. TIME OF INJURY Month, Day, Year <u>11 a.m. 8-19-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) (County) (State) <u>Bethesda Monty md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>8-27-60</u>		
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>		
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Jaska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 31 '60</u>		
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9252 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
09299											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>29 Silver Spring</u>					
c. LENGTH OF STAY IN lb <u>13 yrs</u>						d. STREET ADDRESS <u>19106 Woodland Dr</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9106 Woodland</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Virginia Gertrude Huseman</u>						4. DATE OF DEATH <u>Aug 6 1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-1918</u>		9. AGE (In years last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-C</u>	
13. FATHER'S NAME <u>James T. Treu</u>						14. MOTHER'S MAIDEN NAME <u>Gertrude E. Woodworth</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>577-18-0480</u>		17. INFORMANT <u>Gertrude Floyd - (mother)</u> Address <u>813 1st St. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u> <u>970.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asphyxiation Taken 30 Ethobarbital caps.</u> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8-7-60</u> ACTUAL SIGNATURE <u>Frank J. Broschütz</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschütz</u> Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>8/10/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u> 22d. LOCATION (City, town, or country) (State) <u>WASHINGTON, D.C.</u> 23. FUNERAL DIRECTOR <u>WAYNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u> 24a. REC'D BY REGISTRAR <u>DATE AUG 9 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

THE STATE
OF NEW YORK
IN SENATE
JANUARY 19, 1902

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REPORT
OF THE
COMMISSIONER
OF THE
LAND OFFICE
IN RESPONSE
TO A RESOLUTION
PASSED BY THE
SENATE, MAY 1, 1901

02572 MINERAL EXAMINER'S CERTIFICATE OF DEATH

MINERAL EXAMINER'S CERTIFICATE OF DEATH
No. 02572
Name of Deceased
Date of Death
Place of Death
Cause of Death
Signature of Examiner
Date of Certificate

MINERAL EXAMINER'S CERTIFICATE OF DEATH
No. 02572
Name of Deceased
Date of Death
Place of Death
Cause of Death
Signature of Examiner
Date of Certificate

MINERAL EXAMINER'S CERTIFICATE OF DEATH
No. 02572
Name of Deceased
Date of Death
Place of Death
Cause of Death
Signature of Examiner
Date of Certificate

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9253

CERTIFICATE OF DEATH

09300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 14 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 416 E. MELBOURNE AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAGGIE Middle EUGENE Last JACKSON				4. DATE OF DEATH Month AUGUST Day 12 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/24/74	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Parsley				14. MOTHER'S MAIDEN NAME Catherine Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Miss Florence W. Jackson, 416 E. Melbourne Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO ? (c) Hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 19 52 to 1 2 Aug 19 60 , that I last saw the deceased alive on 10 Aug 19 60 , and that death occurred at 10:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9006 Colossus Rd Silver Spring, Md DATE SIGNED 8/12/60							
ACTUAL SIGNATURE William D. Aud M.D.							
PHYSICIAN'S NAME (Type) WILLIAM D. AUD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/16/60		22c. NAME OF CEMETERY OR CREMATORY MT. TABOR CEMETERY		22d. LOCATION (City, town, or county) (State) ETCHISON, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.				24a. REC'D BY REGISTRAR SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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RECEIVED

AT RABON COUNTY

THOMAS H. HARRIS

WILLIAM J. AND

AT RABON COUNTY

THOMAS H. HARRIS

RECEIVED

AT RABON COUNTY

THOMAS H. HARRIS

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RECEIVED

AT RABON COUNTY

THOMAS H. HARRIS

RECEIVED

AT RABON COUNTY

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THOMAS H. HARRIS

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9274 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09301											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>Do A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San + Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8613 Piney Br. Rd</u>					
3. NAME OF DECEASED (Type or print) <u>Lucy Lee Kaercher</u>						4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1960</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-6-74</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Government</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Young</u>						14. MOTHER'S MAIDEN NAME <u>Denty</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Marguerite Kyle</u> Address <u>Same Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>8-21-60</u>		
EXAMINER'S NAME (Type) <u>Frank J. Broschant</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) <u> </u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR <u>Francis Gallino</u> Address <u>Wash. D.C.</u> <u>3821-14th St. N.W.</u>						24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> DATE <u>AUG 23 '60</u>			

8271

FOR DATA

1970-01-01

(M)

(1)

10301

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

U.S. GPO

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9374

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10455

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saraland</i>		c. LENGTH OF STAY IN 1b <i>17 mths</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>12921 Columbia Road</i>		d. STREET ADDRESS <i>8408 Flower Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>IDA</i> Middle <i>JANE</i> Last <i>KELLER</i>		4. DATE OF DEATH Month <i>August</i> Day <i>30</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1, 1871</i>
9. AGE (In years, lost birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Not available</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Smith</i>		14. MOTHER'S MAIDEN NAME <i>Not Available</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Not available</i>	
17. INFORMANT <i>John M. Keller, 8408 Flower Ave. T. Rd</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Influenza & Cockey pie</i> DUE TO (c) <i>4 wks</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <i>Fracture Rt 3rd & 4th Ribs</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Was walking in Room & fell by chair</i>	
20c. TIME OF INJURY Month, Day, Year <i>10:30 a.m. Aug 27 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Liberating Mont. Md</i> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8:30</i> to <i>8:30</i> that (I) (we) last saw the deceased alive on <i>8:30</i> 19 <i>60</i> and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Roy B. Parsons</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>ROY B. PARSONS</i>		22b. ADDRESS <i>Burtonsville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 18, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery (temporary)</i>		23d. LOCALITY (City, town, or county) <i>Pr. Geo. Co., Md.</i> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Canal St NW DC</i>		25a. REC'D BY REGISTRAR <i>Sep 19 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. House</i>		25c. DATE <i>SEP 19 '60</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9375

CERTIFICATE OF DEATH

09302

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Edmonia</u> Last <u>King</u>				4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 5, 1892</u>	
9. AGE (In years lost birthday) <u>68 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Bernard Gardiner</u>				14. MOTHER'S MAIDEN NAME <u>Inise Bowlin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Sigmoid Colon</u> <u>153.3</u> DUE TO <u>with metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>February</u> , 19 <u>57</u> , to <u>August 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>August 30</u> , 19 <u>60</u> , and that death occurred at <u>10:05 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. McKendree Boyer</u>				ADDRESS (Street, city or town, state) <u>9830 Main Street</u> DATE SIGNED <u>8/30/60</u>			
PHYSICIAN'S NAME (Type) <u>M. McKendree Boyer, M. D.</u>				<u>Damascus, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-1-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Cemetery</u>		22d. LOCATION (City, town, or county) <u>Clarksburg</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest G. Gaither</u>				ADDRESS <u>Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 2 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ernest G. Gaither</u>			

00205

STATE OF TEXAS

1911

FILE

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STATE OF TEXAS

1911

TO THE HONORABLE JUDGE

OF THE DISTRICT COURT

OF THE COUNTY OF

TEXAS

VS.

THE STATE OF TEXAS

VS.

THE STATE OF TEXAS

VS.

THE STATE OF TEXAS

VS.

THE STATE OF TEXAS

VS.

THE STATE OF TEXAS

VS.

THE STATE OF TEXAS

VS.

THE STATE OF TEXAS

VS.

THE STATE OF TEXAS

VS.

THE STATE OF TEXAS

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09303

9376

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>24 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>18504-16th St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CRAVEN JAMES KING</u>				4. DATE OF DEATH Month Day Year <u>Aug. 24 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-5-82</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Virginia U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (Retired) Bureau of Engraving</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia U.S.A.</u>			
13. FATHER'S NAME <u>Craven James King</u>				14. MOTHER'S MAIDEN NAME <u>Helen De Nova Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Charlotte H. Kenworthy</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure & coma</u> 581.0 DUE TO <u>Portal cirrhosis (non-ethanolic)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> (c) <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> to <u>Aug. 24 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug. 24 1960</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George H. Gray, Jr.</u>				22b. DATE SIGNED <u>8/24/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>George H. Gray, Jr., M.D.</u>				22d. ADDRESS <u>4140 Chevy Chase 15, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>8/27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Mausoleum</u>		23d. LOCATION (City, town, or county) (State) <u>St. Prince George Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>Aug 26 '60</u>		25b. REGISTRAR'S SIGNATURE <u>John S. Hunt</u>	

James M. Smith
 (Attorney for Plaintiff)

James M. Smith

Enclosure 2/25/88

Robert L. Johnson, Attorney

Enclosure 2/25/88

Robert L. Johnson, Attorney

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN 1b Rockville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13200 Midway Avenue				d. STREET ADDRESS 13200 Midway Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;">First HermanMiddle RoscoeLast KIRBY</div>				4. DATE OF DEATH Month August Day 1 Year 19 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1908		
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 11 Days 15		IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10b. KIND OF BUSINESS OR INDUSTRY Auto mechanic		11. BIRTHPLACE (State or foreign country) Louden Co. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert L. Kirby				14. MOTHER'S MAIDEN NAME Hattie Arnette				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes Unknown		17. INFORMANT Address Muriel Upton-daughter-same 2d				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hanging DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hung self by neck with clothes line cord							INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung self by neck with clothes line cord					
20c. TIME OF INJURY Month, Day, Year Hour 8-1 p. m. 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rockville		20f. (City or town) (County) (State) Montg. md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Noturol causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE AUG 4 '60		
						24b. REGISTRAR'S SIGNATURE <i>Charles E. ...</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9377

CERTIFICATE OF DEATH

09305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4890 BATTERY LANE		d. STREET ADDRESS 14890 BATTERY LANE	
3. NAME OF DECEASED (Type or print) First LOUIS Middle Last KIRJASSOFF		4. DATE OF DEATH Month August Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 25, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engr.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy -	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathan Kirjassoff		14. MOTHER'S MAIDEN NAME Deborah Kahn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Miss Rose Kirjassoff		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY INSUFFICIENCY 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) CORONARY SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min. 6 years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CA OF PROSTATE - 3 YRS - MYOCARDIAL INFARCTION - 1957.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 , 19____, to 8/23 , 19 60 , that I last saw the deceased alive on 8/17 , 19 60 , and that death occurred at 1045 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8236 1302-18 St NW Wash D.C. DATE SIGNED 8/23/60			
ACTUAL SIGNATURE Samuel Dessoff		M.D. 1302-18 St NW Wash D.C.	
PHYSICIAN'S NAME (Type) Samuel Dessoff			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-25-60	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		22d. LOCATION (City, town, or county) (State) ARLINGTON VA	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-14th St N.W.		24a. REC'D BY REGISTRAR DATE AUG 26 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

934



MAINTAINED

MAINTAINED

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9275

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09306

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>N. J.</i> b. COUNTY <i>✓</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY in 1b <i>10 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Robinsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington San + Hosp</i>			d. STREET ADDRESS <i>State Highway 33</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Male</i>		First <i>Male</i> Middle <i>Kappel</i> Last <i>Kappel</i>		4. DATE OF DEATH <i>8/21/60</i> Month <i>8</i> Day <i>21</i> Year <i>19</i>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>8-22-21</i> yrs. <i>38</i>	
3. FATHER'S NAME <i>Chas. Kappel</i>		11. BIRTHPLACE (State or foreign country) <i>gugoslavia</i>		9. AGE (In years last birthday) <i>38</i> yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? <i>4 in N.S.A</i>	
17. INFORMANT <i>Hospital Record.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY AIR EMBOLISM (DURING BRAIN SURGERY)</i> 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>BRAIN TUMOR, CEREBELLAR, INTRAVENTRICULAR</i>		INTERVAL BETWEEN ONSET AND DEATH <i>SUDDEN</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Blaschant</i>		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Blaschant</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>8-21-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		22b. DATE THEREOF <i>8/22/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hamilton Square, N. J.</i>	
23. FUNERAL DIRECTOR <i>The S.H. Hines Co. Washington, 9, D.C.</i>		24a. REC'D BY REGISTRAR <i>AUG 23 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

2025

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9378

CERTIFICATE OF DEATH

09307

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
f. STREET ADDRESS 1028 Connecticut Ave., N.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Winey Landis				4. DATE OF DEATH Month August Day 1 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1928	
9. AGE (In years lost birthday) 32 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Travel Consultant				10b. KIND OF BUSINESS OR INDUSTRY Travel		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A?							
13. FATHER'S NAME Benjamin L. Landis				14. MOTHER'S MAIDEN NAME Grace Winey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Yes 1950 - 1952				16. SOCIAL SECURITY NO. Not Available			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Abdominal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Teratocarcinoma DUE TO (c) 18 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2-3-weeks							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 5, 1960 to August 1, 1960 , that (I) (we) lost saw the deceased alive on August 1, 1960 , and that death occurred at 10:50a M, from the causes and on the date stated above.							
22a. SIGNATURE Haskins K. Kashima				22b. DATE SIGNED 8-1-60			
22c. PHYSICIAN'S NAME (Type) HASKINS K. KASHIMA, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/3/60		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEM.		23d. LOCATION (City, town, or county) (State) FORT MYER, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawkins Sons				25a. REC'D BY REGISTRAR DATE AUG 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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MEDICAL CERTIFICATION



9378

CERTIFICATE OF DEATH

Continued

Washington, D.C.

July 1953

The Clinical Center, National Institutes of Health, Bethesda, Md.

James H. Hodge, Jr., M.D., Director

John F. Bower, M.D., Chief of Staff

James H. Hodge, Jr., M.D., Director

Hodgins, J. L.

The Medical Record

July 1953

Inter-Abdominal

Neurologic

July 1953

10:00

The Clinical Center, National Institutes of Health, Bethesda, Md.

James H. Hodge, Jr., M.D., Director

Washington, D.C.

July 1953

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9379

09308

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co. Md.</u> <u>2214 3rd St. NW</u> <u>Bethesda</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONG. MAMON SANITARIUM</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence M.</u> Middle <u>Laplin</u> Last <u>Laplin</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-29-1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE W. MATHEWS</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES WARDWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DONALD M. LAFLIN</u>		Address <u>3544 CANYON RIDGE DR ALTADENA, CALIF.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerosis, Pyelonephritis & cystitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1st 1939</u> to <u>Aug 15 1960</u> that (I) (we) last saw the deceased alive on <u>Aug 15 1960</u> and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James H. Fairfield</u>		22b. DATE SIGNED <u>Aug 15 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. Fairfield</u>		22d. ADDRESS <u>1105 D Canal Ave NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>8-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	23d. LOCATION (City, town, or county) (State) <u>SUITLAND, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Guoceri Inc. Inc.</u>		25a. REC'D BY REGISTRAR <u>AUG 17 1960</u>	
ADDRESS <u>1756 Pa. Ave. N.W. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. S. Hines</u>	

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01-308

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

CERTIFICATE OF FINDINGS

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9311
CERTIFICATE OF DEATH

09309
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY Pinellas	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverley Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle Hague Last Laubach		4. DATE OF DEATH Month Aug. Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 2, 1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 6 Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Jefferson, Texas		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James Price Hague		14. MOTHER'S MAIDEN NAME Flora Brinck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. INFORMANT Address Dorothy Laubach Hall 2400 16th. St. N. W.D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 years 10 + years 20 + years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 60 , to Aug 7 , 19 60 , that I last saw the deceased alive on Aug 6 , 19 60 , and that death occurred at 7:27 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3000 Dent Place, NW Wash. D.C. DATE SIGNED Aug 7, 1960			
ACTUAL SIGNATURE R. Stephen Hulburt		M.D. 3000 Dent Place, NW Wash. D.C.	
PHYSICIAN'S NAME (Type) R. Stephen Hulburt, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Berekidone		ADDRESS Wash, D.C.	
24a. REC'D BY REGISTRAR DATE AUG 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

03803

CERTIFICATE OF DEATH

1911

MAINTAINING STATE OF HEALTH - BANGKOK 12

First Name: _____

Second Name: _____

Age: _____

Sex: _____

Marital Status: _____

Occupation: _____

Place of Birth: _____

Religion: _____

Signature of Doctor: _____

Signature of Registrar: _____

Date: _____

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: If a certificate should be executed within 24 hours after death. If a certificate is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the "State Board of Health," or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
SM 7/59

Item 20 Film 270 9-6-60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9276 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09310

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Crittenden</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crittenden</u>			
c. LENGTH OF STAY IN 1b <u>1 day</u>				d. STREET ADDRESS <u>Crittenden Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sanatorium + Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rita Ann Laughlin</u>		First Middle Last		4. DATE OF DEATH <u>Aug 23 1960</u>		Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-04</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vincent Laughlin</u>				14. MOTHER'S MARDEN NAME <u>Ellen Casey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes give number or date of service)</u>		17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Passive hyperemia + edema, pulmonary acute, massive, Post operative</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Aspiration of gastric contents, acute, with fatty change of liver + myocardium</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Aspiration of gastric contents while in recovery room, following gall bladder operation</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hosp.</u>		20f. (City or town) (County) (State) <u>Montg.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>8-24-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>P. Georges County Md.</u>	
23. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll St NW DC</u>				24a. REC'D BY REGISTRAR <u>AUG 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

(M)

(I)

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR AIS (4)
ISM 9/59

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9380
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
09311

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marjorie T. Lawrence</u>		4. DATE OF DEATH <u>Aug. 31 1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1889</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical (Retired)</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
13. FATHER'S NAME <u>Francis Colton</u>		14. MOTHER'S MAIDEN NAME <u>Helen Vander Werker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>6160</u>	
17. INFORMANT <u>Appleton M. R. Lawrence</u>		Address <u>15 Ave Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>331X</u> (b) <u>Cerebral Arteriosclerosis</u> DUE TO <u>5 yrs</u> (c) <u>Hypertension</u> 5 yrs		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-1-44</u> to <u>8-31-60</u> , that (I) (we) last saw the deceased alive on <u>8-30-60</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Andrew J. Betz</u>		22b. DATE SIGNED <u>8-31-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Andrew J. Betz M.D.</u>		22d. ADDRESS <u>5412 Colo Ave N.W. Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/3/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Ch. Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Sunderland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>SEP 2 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

2000

[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]

CERTIFICATE OF DEATH

Reg. Dist. No. **09312**

9381

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 38 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Violet Middle Elsie Last Leach		4. DATE OF DEATH Month August Day 6 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1907
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) N. Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles A. Borth	
14. MOTHER'S MAIDEN NAME Edenbaugh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 473-18-5531		17. INFORMANT MR. G.W. Royak Address Chicago City	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO (b) Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) unknown		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Aug 4 , 19 60 , to Aug 6 , 19 60 , that I last saw the deceased alive on Aug 6 , 19 60 , and that death occurred at 8 AM , from the causes and on the date stated above.	
ACTUAL SIGNATURE John E. Everett M.D.		ADDRESS (Street, city or town, state) 9400 Conn. Ave DATE SIGNED 8/8/60	
PHYSICIAN'S NAME (Type) JOHN E. EVERETT		Kensington Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/10/60	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Giska ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR AUG 12 60	24b. REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Chronic of liver
Hepatic failure

Chronic
Hepatic

CERTIFICATE OF DEATH

Reg. Dist. No.

09313

9382

1. PLACE OF DEATH MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	c. LENGTH OF STAY IN 1b 24 days 14 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 2111 Belvedere Blvd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Victor Lees		4. DATE OF DEATH Month Day Year August 19 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/73
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (State or foreign country) FRANCE
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LAWRENCE LEES		14. MOTHER'S MAIDEN NAME JOSEPHINE. UNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS MARGARET GIFFORD. 107 LIVINGSTON ST. SIL SP.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive heart failure (b) Old myocardial infarction (c) Atherosclerosis, coronary arteries DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate			INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-1, 1960 to 8-18, 1960, that I last saw the deceased alive on 8-18, 1960, and that death occurred at 4:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon S. Rosenberg		ADDRESS (Street, city or town, state) 310 W. Monte Airs. 1960	
PHYSICIAN'S NAME (Type) Roshell, M.D.		DATE SIGNED 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/22/60	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY.	22d. LOCATION (City, town, or county) (State) PRINCE GEORGES CO MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Huntman & Son		24a. REC'D BY REGISTRAR AUG 22 '60	
ADDRESS 5732 GEORGIA AVE NW WASH D.C.		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

Page 4

9383

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09314

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bernard Middle Dwayne Last LEMON		4. DATE OF DEATH Month August Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-60
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard G. LEMON		14. MOTHER'S MAIDEN NAME Ruby Dunbar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bernard G. LEMON, Rt.2, Roanoke, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 754.5 DUE TO Pulmonic Valvular Stenosis, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) congenital			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-9- 19 60 , to 8-10- 19 60 that (I) (we) last saw the deceased alive on 8-10- 19 60 , and that death occurred at 1:00PM on the causes and on the date stated above.			
22a. SIGNATURE John H. Mazur M.D.		22b. DATE SIGNED 11 August 1960	
22c. PHYSICIAN'S NAME (Type) John H. MAZUR, LT. MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-tran		23b. DATE THEREOF 8/11/60	
23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION (City, town, or county) (State) Roanoke Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY		25a. REC'D BY REGISTRAR AUG 12 '60	
25b. REGISTRAR'S SIGNATURE C. S. Evans		25c. ADDRESS 7557 Wisconsin Ave, Bethesda, Md.	

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EXTRACT OF CHART

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9384

09315

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 26 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia d. STREET ADDRESS 3101 Brighton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Barbara Jane Lerch		4. DATE OF DEATH Month August Day 14 Year 19 60					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1943	9. AGE (In years last birthday) 16 yrs.	IF UNDER 1 YEAR Months 12 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania			
13. FATHER'S NAME Charles A. Lerch		14. MOTHER'S MAIDEN NAME Helen G. Hellman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 173-34-1417		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intra-Abdominal Hemorrhage DUE TO (b) Dysgerminoma of Ovary with Teratomatous and Trophoblastic elements. DUE TO (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOTING THE UNDERLYING CAUSE LOST. 175.0				INTERVAL BETWEEN ONSET AND DEATH 12 Hours 8 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) July 19, 19 60			
20f. (City or town) August 14, 19 60		20g. (County) Philadelphia, Pa.		20h. (State) Pa.			
21. I certify that (I) (this hospital) attended the deceased from July 19, 19 60 to August 14, 19 60 , that (I) (we) lost saw the deceased alive on August 14, 19 60 , and that death occurred on August 14, 19 60 from the causes and on the date stated above.							
22a. SIGNATURE Martin Nydick		22b. DATE SIGNED 8-14-60		22c. PHYSICIAN'S NAME (Type) MARTIN NYDICK, M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/60		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery			
23d. LOCATION (City, town, or county) Philadelphia, Pa.		23e. (State) Pa.					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR August 17 '60			
25b. REGISTRAR'S SIGNATURE Charles E. Kraus							

1384

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THE CASE OF DEATH

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THE CASE OF DEATH

1 FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9277

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09316

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7516 Piney Branch Rd</u>				d. STREET ADDRESS <u>7516 Piney Branch Rd</u>			
3. NAME OF DECEASED (Type or print) <u>First Helen Middle Lutkiewitz Last</u>				4. DATE OF DEATH <u>Aug 22 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1984</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.C.</u>	
13. FATHER'S NAME <u>Vincent Dobrosielski</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Vincent Lutkiewitz - Illus 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Fatal drop on bed room floor</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <u>History of previous Cornary disease</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Buschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Buschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Aug 22 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Aug 29 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Raymond A. Jiska</u>			

MEDICAL CERTIFICATION

08316

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09317
Reg. Dist. No.

9385

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Mont. Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN, 1b 2 hrs. 1 day-40 mins. 34		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban			d. STREET ADDRESS 3912- Jeffry Street		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Janet T. Maher			4. DATE OF DEATH Aug. 27, 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1953		9. AGE (In years last birthday) 6 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child - Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MA. BOSTON, MASS.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Walter R. Mah er		
14. MOTHER'S MAIDEN NAME ANGELINA VIOLA			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT PT's. Chart		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration gastric contents under anes- tesia for appendectomy (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 24 hrs 10 min
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Blusch		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-28-60	
EXAMINER'S NAME (Type) FRANK J. Blusch		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/31/60		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	
22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA		22e. (State) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR SEP 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

16/61A filler

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10450

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10471

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Kensington

c. LENGTH OF STAY IN lb

2 mo

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Kensington Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

b. COUNTY

D.C.

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

3914 9th St, N.E.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Julia E

Maley

4. DATE OF DEATH

8-30-60

19

5. SEX

Female

White

housewife

John Morris

(Yes, no, or unknown) (If yes give war or dates of service)

6. COLOR OR RACE

WIDOWED ☒

NEVER MARRIED ☐

DIVORCED ☐

8. DATE OF BIRTH

5-29-75

9. AGE (In years last birthday)

85 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

va

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Lenora Magner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Nursing Home Record

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Congestive heart failure

INTERVAL BETWEEN ONSET AND DEATH
2 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO
(c) DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Fracture left hip - 4 mo ago

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschant

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

8-30-60

EXAMINER'S NAME (Type)

FRANK J. Broschant

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Burial 9-1-60

St. Marys Cemetery, Prince Georges Co. VA

23. FUNERAL DIRECTOR

Limittley Haulon - 3831 GA. AVE.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE SEP 13 '60

Arthur S. Kraus

MEDICAL CERTIFICATION

1
Page 4 after death. Page 4
in by the funeral director,
and 2 should be filled with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon page
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9302

CERTIFICATE OF DEATH

09318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Md. c. LENGTH OF STAY IN 1b 10yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 07 Gaithersburg d. STREET ADDRESS 1 Cedar Ave & Summit Hall Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Arkie Middle Mae Last Marshall		4. DATE OF DEATH Month Aug Day 13 Year 19 60				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29-1906	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 2 Days 14	IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Samuel Butrey			14. MOTHER'S MAIDEN NAME Guiola Drenien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		INFORMANT Jack Marshall. Gaithersburg, Md. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix 171X DUE TO 2 widespread metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH 3 years
21. I certify that I attended the deceased from 5-15 , 19 60 to 8-13 , 19 60 that I last saw the deceased alive on 8-16-60 , 19 60 , and that death occurred at 10:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 Russell Ave. 8-15-60 ACTUAL SIGNATURE Jack Schumacher M.D. PHYSICIAN'S NAME (Type) Jack Schumacher Gaithersburg, Md.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-16-60		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Emush G. Galtner, Gaithersburg, Md.			24a. REC'D BY REGISTRAR DATE AUG 18 '60		24b. REGISTRAR'S SIGNATURE Galtner S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09319

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3 D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM-HOSP.</u>				d. STREET ADDRESS <u>804 VAN BUREN ST. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>MAXWELL</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-19-85</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MAINTENANCE</u>			
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>James B. Maxwell</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-28-0290A</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Bronchopneumonia</u> DUE TO (b) <u>Pyleonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>metastatic carcinoma (Mtg.)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>60 days</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6:20</u> <u>1960</u> to <u>8:5</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>8-5-60</u> <u>19</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard L. Clapp</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-6-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard L. Clapp MD</u>				22d. ADDRESS <u>Wash. Sanit. & Hosp.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>Aug. 10, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	
23d. LOCATION (City, town, or county) <u>Pr. Geo. Co., Md.</u>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>				ADDRESS <u>1400 Chapin St. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
25b. REGISTRAR'S SIGNATURE				DATE <u>AUG 11 '60</u>			

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 9279
 CERTIFICATE OF DEATH

09320

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
c. LENGTH OF STAY IN 1b <u>1 week</u>				d. STREET ADDRESS <u>1915 K St. NW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>McArter</u>				4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-16-99</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>60</u> Days <u>60</u> Hours <u>60</u> Min.		IF UNDER 24 HRS. Months <u>60</u> Days <u>60</u> Hours <u>60</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gov't disability</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>John R McArter</u>				14. MOTHER'S MAIDEN NAME <u>Julia M Gaynor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordio vasulor renal failure</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Adenocarcinoma of Rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Granulomatous condition of Liver, cause undetermined</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>1 year</u> <u>8 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>Aug 8</u> , 19 <u>60</u> , to <u>Aug 8</u> , 19 <u>60</u> , that (I) <u>last</u> saw the deceased alive on <u>Aug 8</u> , 19 <u>60</u> , and that death occurred at <u>9:45</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>W W Eastman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>Aug 8, 1960</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>8700 Colesville Rd., Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8-11-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bedon Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Switzland Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon</u> ADDRESS <u>3831 Ga Ave NW</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

I, the undersigned, being a resident of the County of ... State of ... do hereby certify that on the ... day of ... 1933, at ... in the County of ... State of ... was born to ... and ... a child of the marriage of ... and ... the child's name is ...

The child was born at ... in the County of ... State of ... and was born at ... o'clock ... of the day ...

Witness my hand and seal of office this ... day of ... 1933.
Attest my hand and seal of office this ... day of ... 1933.
The undersigned, being a resident of the County of ... State of ... do hereby certify that on the ... day of ... 1933, at ... in the County of ... State of ... was born to ... and ... a child of the marriage of ... and ... the child's name is ...

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

9254

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09321

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1122 Dennis Avenue</u>		d. STREET ADDRESS <u>1122 Dennis Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harriett Emaline McCambridge Harriett</u>		4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1868</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Coolidge</u>		14. MOTHER'S MAIDEN NAME <u>Ann M. Perry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Randolph McCambridge</u>		Address <u>1122 Dennis Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary edema</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> 19 <u>60</u> to <u>August 15</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>August 15</u> 19 <u>60</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw Jr.</u>		22b. DATE SIGNED <u>Aug 15, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw Jr.</u>		22d. ADDRESS <u>345 University Blvd. W. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>8/15/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>AUG 16 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

1951

RECEIVED

1951

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9312
CERTIFICATE OF DEATH

09322

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b X Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 E. Middle Lane		d. STREET ADDRESS 126 S. VanBuren St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle G. Last McDONALD		4. DATE OF DEATH Month August Day 25, Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1898
9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 3 Days 20	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Private Industry	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Grant McDonald		14. MOTHER'S MAIDEN NAME ? Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W. W. I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Wife Address Dorothy Higgins McDonald-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Rheumatic heart disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 30 min 19 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) congestive heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-12-1959 to 8-25-1960 that (I) (we) lost saw the deceased alive on Aug 25, 1960 , and that death occurred at 2:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Stephen C. Cromwell M.D.		22b. DATE SIGNED 3-25-60	
22c. PHYSICIAN'S NAME (Type) STEPHEN C. CROMWELL		22d. ADDRESS 615 W. Montgomery Ave, Rockville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-27-60	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		25a. REC'D BY REGISTRAR DATE AUG 29 '60	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

03329

CERTIFICATE OF DEATH

9312

Montgomery

Rockville

Montgomery

Rockville

Rockville

120 S. Vermont St.

110 E. Spaulding Lane

G. McDONALD

JOHN

May 5 1886

Male

Private Industry

Civil Engineer

Washington, D.C.

Kelly

Charles Grant McDonald

Wife

Unknown

Dorothy Higgins McDonald - same last

STEPHEN C. GORMAN

Rockville Co. Sec'y

5-27-60

Rockville

Bethesda, Md.

ROBERT A. WILSON

CERTIFICATE OF DEATH

Reg. Dist. No. 09323

9386

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 2822 Rittenhouse St. N.W.	
3. NAME OF DECEASED (Type or print) First William Middle R Last Mc Kinley		4. DATE OF DEATH Month Aug. Day 7 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/08
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Adm. Officer		10b. KIND OF BUSINESS OR INDUSTRY CIA	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Kerchoff		14. MOTHER'S MAIDEN NAME Charlotte Mc Kinley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wife (Helen) Same as Above		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 17 days. 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/7 , 19 60 , to 8/7 , 19 60 , that I last saw the deceased alive on 8/7 , 19 60 , and that death occurred at 7:53 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James W. Egan		ADDRESS (Street, city or town, state) 7720 Wisconsin Ave., Bethesda, Md.	
PHYSICIAN'S NAME (Type) James W. Egan		DATE SIGNED 8/7/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 8/9/1960	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR AUG 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Page 4

low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FBI
JAN 11 1964

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CERTIFICATE OF DEATH

1964

UNITED STATES DEPARTMENT OF HEALTH - BIRMINGHAM

1. Name of deceased: _____
2. Sex: _____
3. Race: _____
4. Date of birth: _____
5. Date of death: _____
6. Place of death: _____
7. Cause of death: _____
8. Manner of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____
12. Place of registration: _____

13. Name of informant: _____
14. Address of informant: _____
15. City and State: _____
16. Date of completion: _____
17. Registrar's signature: _____
18. Registrar's title: _____
19. Registrar's address: _____
20. Registrar's phone: _____

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FOR STATE
HEALTH DEPT. (M)
X
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
9255 09324									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				
c. LENGTH OF STAY IN TB <u>2 mo</u>					d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9406 Russell Rd</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					8. STREET ADDRESS <u>19406 Russell Rd</u>				
3. NAME OF DECEASED (Type or print) <u>Nora Marie Mc Lane</u>					4. DATE OF DEATH <u>Aug 11 1960</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>8-24-10</u>				
9. AGE (In years last birthday) <u>49</u> yrs.					IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club Gov.</u>					11. BIRTHPLACE (State or foreign country) <u>DC</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>					13. FATHER'S NAME <u>Roger Cullinans</u>				
14. MOTHER'S MAIDEN NAME <u>Eliz Whalen</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				
16. SOCIAL SECURITY NO. <u>Simon Mc Lane</u>					17. INFORMANT <u>Simon Mc Lane</u> Address <u>Stun 2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO <u>Hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
<u>War under psychiatric care</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Hung self by neck in basement of her home</u>									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>19</u>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>basement of her home</u>									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <u>8-11-60</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-16-60</u>									
22b. DATE THEREOF <u>8-16-60</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>									
22d. LOCATION (City, town, or country) (State) <u>Wash. DC</u>									
23. FUNERAL DIRECTOR <u>Thomas B. Harker</u> ADDRESS <u>3831- 14th Ave NW</u>									
24a. REC'D BY REGISTRAR <u>Aug 18 '60</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harker</u>									

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9280

CERTIFICATE OF DEATH

09325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Rockville			
f. STREET ADDRESS 12803 Parkland Drive				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nettie C. (MMA) Melton				4. DATE OF DEATH Month Day Year Aug. 2 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-84 5/9/83 77 yrs.	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Cloud				14. MOTHER'S MAIDEN NAME Annie Biggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Thaddeus B. Melton, 12,803 Parkland Drive Rockville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO 433.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 25, 19 60 , to Aug 2, 19 60 , that I last saw the deceased alive on Aug 2, 19 60 , and that death occurred at 230 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10,620 Ga. Ave., Silver Spring, Md. DATE SIGNED 8/3/60 ACTUAL SIGNATURE W. Y. Marcus M.D. PHYSICIAN'S NAME (Type) W. Y. Marcus							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8/5/60		22c. NAME OF CEMETERY OR CREMATORY ORLEAN CEMETERY	
22d. LOCATION (City, town, or county) (State) ORLEAN, FARQUIER CO., VIRGINIA							
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR AUG 5 '60	
24b. REGISTRAR'S SIGNATURE William S. Hanna							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9313

CERTIFICATE OF DEATH

09326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 10 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 914 Viers Mill Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Myrtle Middle Elizabeth Last Melvin				4. DATE OF DEATH Month August Day 8 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1908	9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Mayhew				14. MOTHER'S MAIDEN NAME Elizabeth Mobley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Thomas C. Melvin Address Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF COLON DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						INTERVAL BETWEEN ONSET AND DEATH ONE HOUR ONE YEAR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1959 to August 8, 1960 , that I last saw the deceased alive on August 7, 1960 , and that death occurred at 12:48 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon S. Rosenberger M.D.				ADDRESS (Street, city or town, state) 310 West Montgomery Ave. Rockville, Md.			
DATE SIGNED Aug 8, 1960							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-60		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Mont. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR AUG 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0313

03030

For use by

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 10 1903	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		None	
BIRTHPLACE		PLACE OF BIRTH	
MD		MD	
MARRIED		CAUSE OF DEATH	
Yes		Heart Disease	
SPOUSE'S NAME		MANNER OF DEATH	
Mary H. Harris		Natural	
DATE OF MARRIAGE		PLACE OF DEATH	
Jan 10 1903		MD	
EDUCATION		RELIGION	
High School		None	
SPECIAL OCCASION		SIGNATURE OF PHYSICIAN	
None		J. H. Harris	
SIGNATURE OF REGISTRAR		OFFICIAL USE	
J. H. Harris		None	

0387

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STATE OF NEW YORK
IN SENATE
January 12, 1904.
REPORT
OF THE
COMMISSIONERS OF THE
LAND OFFICE
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
MAY 1, 1903.
ALBANY:
J. B. LIPPINCOTT
PRINTERS.
1904.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9281

CERTIFICATE OF DEATH

Reg. Dist. No. 10482

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN b. 1 day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hosp.				d. STREET ADDRESS 7009 Poplar Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Lee Last Messenger				4. DATE OF DEATH Month Aug. Day 14 Year 19 60							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1960		9. AGE (In years last birthday) yrs. 0 18 29		IF UNDER 1 YEAR Months 0 Days 18 Hours 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (State or foreign country) United States			
13. FATHER'S NAME Virgil Lee Messenger				14. MOTHER'S MAIDEN NAME Branda June Cunningham							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. -		17. INFORMANT Mother		Address (same as above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 776X DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 13 , 19 60 , to Aug. 14 , 19 60 , that I last saw the deceased alive on Aug. 14 , 19 60 , and that death occurred at 12:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1605 N. PORTER DR. N.W. WASH. D.C. DATE SIGNED ALLAN B. COLEMAN											
ACTUAL SIGNATURE ALLAN B. COLEMAN M.D.				PHYSICIAN'S NAME (Type) ALLAN B. COLEMAN WASH. D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremated				22b. DATE THEREOF 10-3-60		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hospital-Takoma Park, Md.		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D. Washington SAN.						24a. REC'D BY REGISTRAR DATE NOV 5 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

9388

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09328

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 139 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Herndon		83X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS Route 666, Box 332		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle Lorraine Last Miller				4. DATE OF DEATH Month August Day 30 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 10, 1904		9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Nurse		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis L. Barr				14. MOTHER'S MAIDEN NAME Sue Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-44-0210		17. INFORMANT The Medical Record, The Clinical Center, NIH, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO bone and (b) Carcinoma of left breast with lung metastasis DUE TO 10 years (c) Left ventricular hypertrophy DUE TO 20 years						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from April 13, 1960 to August 30, 1960 , that (he) (we) last saw the deceased alive on August 30, 1960 , and that death occurred at 1:00 PM from the causes and on the date stated above.							
22a. SIGNATURE Leo L. Stolbach				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/30/60	
22c. PHYSICIAN'S NAME (Type) Leo L. Stolbach, M.D.				22d. ADDRESS The Clinical Center, NIH, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, or other disposal (Specify) Burial Aug 31, 1960 Chestnut Grove Cemetery		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Herndon, Va.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. Berkley Green - Green Funeral Home, Herndon, Va.				25a. RECEIVED BY REGISTRAR SEP 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

9382

9382

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Signature. Includes a large circular stamp on the right side.

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
SIGNATURE: [illegible]

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 9282 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09329

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs</u>				d. STREET ADDRESS <u>116 Lee Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>apt 207</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Engineer Adam Monts</u>				4. DATE OF DEATH <u>Aug 16 1960</u>			
5. SEX <u>male</u>				6. COLOR OR RACE <u>white</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5-24-1902</u>			
9. AGE (In years) <u>58</u> yrs.				10. AGE (In years) IF UNDER 1 YEAR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>— — —</u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James A Monts</u>				14. MOTHER'S MAIDEN NAME <u>Dominick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>250-09-9228</u>			
17. INFORMANT <u>Sarah Monts (wife)</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>8-16-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>8-18-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELMWOOD CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>COLUMBIA, S.C.</u>	
23. FUNERAL DIRECTOR <u>Joseph Pawlowski, Inc. 1756 Pa. Ave. NW</u>				24a. REC'D BY REGISTRAR <u>AUG 22 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 90 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		47 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resnor Hospital				d. STREET ADDRESS 1673 Columbia Road, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Timothy Middle F. Last Murphy				4. DATE OF DEATH Month August Day 29 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5, 1875	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician retired				10b. KIND OF BUSINESS OR INDUSTRY Medical		11. BIRTHPLACE (State or foreign country) Leviston, Maine	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Thomas J. Murphy				14. MOTHER'S MAIDEN NAME Marion Downey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT U.S. Embassy Son. Mr. Elliott Murphy San Jose, Costa Rica			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) gangrene right foot DUE TO (c) arteriosclerosis, generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 6 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to August 27, 1960 that (I) (we) last saw the deceased alive on August 27, 1960 and that death occurred at 6:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Wilfred R. E. Herman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/28/60	
22c. PHYSICIAN'S NAME (Type) Wilfred R. E. Herman				22d. ADDRESS 4890 Battery Lane, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-3-1960		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gaudin's Sons, Inc.				ADDRESS 1756 Pa. Ave. N.W.		25a. REC'D BY REGISTRAR DATE SEP 2 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

03630

CERTIFICATE OF DEATH

1110210



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

Reg. Dist. No. 0224

9390

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 85 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Connecticut c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheshire d. STREET ADDRESS 272 Bates Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosemary Frances Murty		4. DATE OF DEATH Month Day Year August 15, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1931
9. AGE (In years last birthday) 28 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Connecticut
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John T. Wilson	
14. MOTHER'S MAIDEN NAME Rosemary Kennedy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 049-24-8680		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis, chronic, of unknown cause 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sigmoid diverticulum with perforation and abscess formation 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from May 22, 1960 to August 15, 1960 , that I last saw the deceased alive on August 15, 1960 , and that death occurred at 10:55 P. M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-16-60 ACTUAL SIGNATURE Philip Fireman M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Philip Fireman, M.D. Bethesda 14, Maryland			
22. INTERVAL BETWEEN ONSET AND DEATH 6 months			
23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
24. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit			
25. DATE THEREOF 8/19/60			
26. NAME OF CEMETERY OR CREMATORY St. Bridgets			
27. LOCATION (City, town, or county) (State) Cheshire Connecticut			
28. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home			
29. ADDRESS 1331 E. Montg. Ave. Rockville, Md.			
30. REC'D BY REGISTRAR Ave			
31. DATE Aug 19 '60			
32. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9391

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09332

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 5 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 76 West Rennell Avenue d. STREET ADDRESS Lexington Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joyce Middle Ann Last NEHL				4. DATE OF DEATH Month AUGUST Day 18 Year 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-17-60	
9. AGE (In years last birthday) 7		10. IF UNDER 1 YEAR Months 7 Days 44		11. IF UNDER 24 HRS. Hours 44 Min. 44		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert J. NEHL				14. MOTHER'S MAIDEN NAME Sharon E. ROBINSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Robert J. NEHL, Same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Asphyxia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-18-60 to 8-18-60 , that (I) (we) last saw the deceased alive on 8-18-60 , and that death occurred at 7:40AM from the causes and on the date stated above.							
22a. SIGNATURE Fred W. Grello				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 8-18-60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-18-60		23c. NAME OF CEMETERY OR CREMATORY Holy Face		23d. LOCATION (City, town, or county) (State) Lexington Park, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE TYSON WHEELER FUNERAL HOME, ROCKVILLE, MD.				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE AUG 22 '60				DATE AUG 22 '60		DATE AUG 22 '60	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09333

9392

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Md. 50</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6101 Kentbury Dr., Bethesda, Md.</u>		d. STREET ADDRESS <u>6101 Kentbury Drive, 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Josephine</u> Last <u>Nugent</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1916</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alonzo H. Travers.</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANNE McCANN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None.</u>	
17. INFORMANT <u>Mrs. Cornelia N. Tudden, Bethesda, Md.</u>		Address <u>8101 Kentbury Dr., Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia and shock.</u> DUE TO (b) <u>Gastrointestinal hemorrhage.</u> DUE TO (c) <u>Thrombocytopenic purpura</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> <u>15 mins.</u> <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>June 1, 1958</u> to <u>Aug 28, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 28, 1960</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>George A. Gray, Jr.</u>		22b. DATE SIGNED <u>Aug 28, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>George A. GRAY, JR., MD</u>		22d. ADDRESS <u>4140 Chevy Chase Dr., Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 30, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Alexandria, Virginia.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Nijm</u>		25a. REC'D BY REGISTRAR <u>Aug 31 '60</u>	
ADDRESS <u>520 S. Washington St. Alexandria, Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>	

9314

CERTIFICATE OF DEATH

09334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>611 Stonestreet Ave.</i>		d. STREET ADDRESS <i>611 Stonestreet Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Helen Rebecca Page</i>		4. DATE OF DEATH <i>8 8 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 12 1934</i>
9. AGE (in years last birthday) <i>25</i> yrs.		10. IF UNDER 1 YEAR <i>25</i> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Walter Edward Giddings</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Helen Darsey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>191-9</i> DUE TO <i>Broncho-Pneumonia, acute</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Epi-thelioma, naso-pharynx with</i> DUE TO <i>metastasis</i> (c) <i>-</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i> <i>2 1/2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Inanition</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb.</i> , 19 <i>58</i> , to <i>8-8</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>8-8</i> , 19 <i>60</i> , and that death occurred at <i>839</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>202 Martin La., Rockville</i> DATE SIGNED <i>8-9-60</i>			
ACTUAL SIGNATURE <i>Clive E. Jackson</i>		M.D. <i>202 Martin La., Rockville</i>	
PHYSICIAN'S NAME (Type) <i>Clive E. Jackson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/11/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion.</i>	22d. LOCATION (City, town, or county) (State) <i>Mt. Zion, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS <i>Rockville, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>AUG 15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Arnold</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20

1. The purpose of this study is to determine the effect of the new vaccine on the incidence of disease in children aged 12-23 months.

2. The study was conducted in a community health center in a large city.

3. The study was a randomized, controlled trial.

4. The study was conducted from January 1, 1980, to December 31, 1981.

5. The study was conducted in a community health center in a large city.

6. The study was a randomized, controlled trial.

7. The study was conducted from January 1, 1980, to December 31, 1981.

8. The study was conducted in a community health center in a large city.

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Signature

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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9393

CERTIFICATE OF DEATH

09335

Item 1 Film 62-70 9-6-60 et

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 271 277 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 1416 Quebec Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alvina Middle Marie Last Parise		4. DATE OF DEATH Month August Day 30 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1923
9. AGE (In years lost birthday) 36 yrs.		IF UNDER 1 YEAR Months 36 Days 36 Hours 36 Min. 36	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius Moermond		14. MOTHER'S MAIDEN NAME Marie Overnan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMANT The Medical Record		Address The Clinical Center, NIH, Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 201X IMMEDIATE CAUSE (a) Brain abscess DUE TO (b) Pseudomonas septicemia DUE TO (c) Hodgkin's Disease		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that () (this hospital) attended the deceased from December 3, 1959 to August 30, 1960 that () (we) last saw the deceased alive on August 30, 1960 , and that death occurred at 1:18 PM from the causes and on the date stated above.			
22a. SIGNATURE Vincent H. Bono, Jr.		22b. DATE SIGNED 8/30/60	
22c. PHYSICIAN'S NAME (Type) Vincent H. Bono, Jr., M.D.		22d. ADDRESS The Clinical Center, NIH, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-2-60	
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (City, town, or county) (State) WHEATON, MD	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Taltavull		25a. REC'D BY REGISTRAR SEP 1 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

88890

CERTIFICATE OF DEATH

9332

DEPARTMENT OF HEALTH
STATE OF NEW YORK

DATE OF DEATH

PLACE OF DEATH

AGE

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

AGE

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

SEX

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9315

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09236

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)	
Montgomery MARYLAND		a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 817 Lynn Ct.		d. STREET ADDRESS 817 Lynn Ct.	
3. NAME OF DECEASED (Type or print) Diana Lynn Parsons		4. DATE OF DEATH Aug. 7, 1960	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/12/1960	
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months 2 Days 25	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Jannette Parsons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wash. Home for foundlings, D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Upper Respiratory Infection (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH Found dead in bed.	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 8/7/60	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
28. BURIAL, CREMATION, REMOVAL (Specify) Cremation		29. DATE THEREOF 8/8/1960	
30. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		31. LOCATION (City, town, or country) (State) Suitland Maryland	
32. FUNERAL DIRECTOR Robert A. Pumphrey		33. ADDRESS Bethesda, Maryland	
34. REC'D BY REGISTRAR DATE AUG 9 '60		35. REGISTRAR'S SIGNATURE Arthur L. Harris	

STATE OF ARIZONA, DEPARTMENT OF HEALTH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9394 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09337

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>37 Wheaton</u>		d. STREET ADDRESS <u>1 2606 Elmont st</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2606 Elmont st</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Samuel mark Pearson</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-7-1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dealer - Wash. Post - retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State of foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Pearson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>Helena Pearson (wife)</u>		17. INFORMANT <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>8-6-60</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 10, 1960</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR <u>Real Funeral Home</u>				ADDRESS <u>4812 Le Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

Wash DC

(A)

(1)

LABORATORY REPORT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-100

100-100

100-100

100-100

100-100

100-100

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100-100

100-100

100-100

X

X

X

100-100

100-100

100-100

100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9395

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09338

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 95 East Wayne Street, Apt. # 1							
3. NAME OF DECEASED (Type or print)		First Carol Middle Ann Last Persun		4. DATE OF DEATH		Month August Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1954		9. AGE (In years last birthday) 6 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emil M. Persun				14. MOTHER'S MAIDEN NAME Eutha Mae Pumphrey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cystic Fibrosis 587.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
INTERVAL BETWEEN ONSET AND DEATH 6 Years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 22, 1960 to August 26, 1960 that (I) (we) last saw the deceased alive on August 26, 1960 and that death occurred at 7:10 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Hugh Evans				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/26/60	
22c. PHYSICIAN'S NAME (Type) Hugh Evans, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/29/60		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEORGES COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				25a. REC'D BY REGISTRAR SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Charles E. Hume	
				DATE AUG 30 '60			

MEDICAL CERTIFICATION

1

28

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M

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2332

10338

CERTIFICATE OF DEATH

1 day

2-11-1941

White

Male

John A. Brown

City

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

9283

CERTIFICATE OF DEATH

09339
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>?</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San and Hosp.</u>		d. STREET ADDRESS <u>630 Sheridan Street</u>	
3. NAME OF DECEASED (Type or print) <u>Frances. Marian Phares</u>		4. DATE OF DEATH Month <u>aug</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Secy. St. E. J. Hosp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Der worth Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>Amer.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Frank Fraley</u>		14. MOTHER'S MAIDEN NAME <u>Vanda Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-56-7053</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 years</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-sclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 29, 1957</u> to <u>Aug 20, 1960</u> that I last saw the deceased alive on <u>Aug 20, 1960</u> and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10620 George 19 Ave Aug 20, 1960</u>			
ACTUAL SIGNATURE <u>George L Ball</u>		M.D. <u>10620 George 19 Ave Aug 20, 1960</u>	
PHYSICIAN'S NAME (Type) <u>George L Ball</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co</u>		ADDRESS <u>2901 Washington D C</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9398

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09340

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 90 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 11708 Idlewood Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Aloysius Last Phelps, II				4. DATE OF DEATH Month August Day 21 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 19, 1946	
9. AGE (In years lost birthday) 13 yrs.		IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min.		IF UNDER 24 HRS. Months 13 Days 13 Hours 13 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert A. Phelps, Sr.				14. MOTHER'S MAIDEN NAME Carolyn Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphocytic Leukemia DUE TO (c) 4 months						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23, 1960 to August 21, 1960 , that (I) (we) last saw the deceased alive on August 21, 1960 , and that death occurred 3:25 a.m. from the causes and on the date stated above.							
22a. SIGNATURE R. E. Rieselbach				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-21-60	
22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/24/60		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. DUMPHREY, INC. <i>Raymond A. Jirka</i>				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE AUG 25 '60	
				25b. REGISTRAR'S SIGNATURE <i>Clara S. Kraus</i>			

CERTIFICATE OF DEATH

1. Name of deceased: Robert A. Thompson
2. Date of death: 20 days
3. Place of death: The National Cemetery, Arlington, D.C.
4. Cause of death: Heart disease
5. Age at death: 42
6. Sex: Male
7. Race: White
8. Date of birth: 1910
9. Place of birth: Washington, D.C.

10. Name of informant: Robert A. Thompson
11. Address of informant: The National Cemetery, Arlington, D.C.
12. Signature of informant: [Signature]
13. Date of completion: 20 days

14. Name of physician: [Signature]
15. Address of physician: [Address]
16. Signature of physician: [Signature]
17. Date of completion: 20 days

18. Name of registrar: [Signature]
19. Address of registrar: [Address]
20. Signature of registrar: [Signature]
21. Date of completion: 20 days

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9397

CERTIFICATE OF DEATH

09341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day-4hrs.30mins. X Germantown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 1 None	
3. NAME OF DECEASED (Type or print) First Roy Middle M. Last Plummer		4. DATE OF DEATH Month Aug Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1905
9. AGE (In years lost birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Operator		10b. KIND OF BUSINESS OR INDUSTRY State Rd. Comm.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Plummer		14. MOTHER'S MAIDEN NAME Lidie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-18-8487	
17. INFORMANT Gladys L. Plummer/Same as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443 IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 30 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/8/60 , 19 60 , to 8/9 , 19 60 , that I lost the deceased alive on 8/9/60 , 19 60 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John E. Everett M.D.		ADDRESS (Street, city or town, state) 9400 Conn. Ave DATE SIGNED 8/9/60	
PHYSICIAN'S NAME (Type) JOHN E. EVERETT		Kensington, Md	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 8/12/60	
22c. NAME OF CEMETERY OR CREMATORY Emory Grove		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. Snowden ADDRESS Rockville, Md		24a. REC'D BY REGISTRAR AUG 12 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1930

11

11



TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9398

09342

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY Lexington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 65 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Donald Norris POWELL		4. DATE OF DEATH AUGUST 10 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 December 1915
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William POWELL		14. MOTHER'S MAIDEN NAME Annie LITRELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII Korean		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia M. Powell 318 Given Lexington, Ky.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Approx 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4 June 19 60 to 10 August 19 60 , that (I) (we) lost saw the deceased alive on 10 August 19 60 , and that death occurred at 1:10 AM from the causes and on the date stated above.		22a. SIGNATURE Kenneth V. Harshman M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 10 Aug 60	
22c. PHYSICIAN'S NAME (Type) Kenneth V. Harshman, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-60	
23c. NAME OF CEMETERY OR CREMATORY Lexington Cemetary		23d. LOCATION (City, town, or county) (State) Lexington, Ky.	
24. FUNERAL DIRECTOR'S SIGNATURE CHAMBERS FUNERAL HOME 1400 Chapin St., N.W., Wash. D.C. AUG 15 '60		25a. REC'D BY REGISTRAR Arthur S. Harris	
25b. REGISTRAR'S SIGNATURE			

00348

CERTIFICATE OF DEATH

1308



NAME

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

U.S. Social Security Number

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9399

CERTIFICATE OF DEATH

09343

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
f. STREET ADDRESS 7008 9th Street, N.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Nicholas Last Preftakes				4. DATE OF DEATH Month August Day 5 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892 January 14th, 1890	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 68 Hours rs.		IF UNDER 24 HRS. Months 70 Days 68 Hours rs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant owner				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Nicholas Preftakes				14. MOTHER'S MAIDEN NAME Margaretta Dovalis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 221-01-1881			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myelogenous Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 hrs. 1 mo.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 2, 19 60 to August 5, 19 60 , that (I) (we) last saw the deceased alive on August 5, 19 60 , and that death occurred 6:50a M, from the causes and on the date stated above.							
22a. SIGNATURE Edward E. Morse				22b. DATE SIGNED 8/5/60			
22c. PHYSICIAN'S NAME (Type) EDWARD E. MORSE, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/8/60		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Zicka				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE AUG 9 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10348

CONTINUITY OF CARE

9331

Minister of Columbia

Washington

3 days

Residence

YOUR OWN OFFICE, S. S.

The Medical Center, Bethesda, Md.

August

Provision

Neurological

January 1941, 1942

1941

1941

1941

U. S. S.

Provision

Provision

Provision

Minister of Columbia

Minister of Columbia

The Medical Center

Neurological, The Medical Center, Bethesda, Md.

1941

Neurological

1941

Neurological

1941

The Medical Center, Bethesda, Md.

Neurological, The Medical Center, Bethesda, Md.

Neurological, The Medical Center, Bethesda, Md.

Neurological, The Medical Center, Bethesda, Md.

Neurological, The Medical Center, Bethesda, Md.

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Neurological, The Medical Center, Bethesda, Md.

Neurological, The Medical Center, Bethesda, Md.

Neurological, The Medical Center, Bethesda, Md.

Neurological, The Medical Center, Bethesda, Md.

9400

CERTIFICATE OF DEATH

09344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X2</u>	
c. LENGTH OF STAY IN lb <u>3 wks.</u>		d. STREET ADDRESS <u>3201 Cathedral Ave. NW</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverley Sanitarium</u>		e. STREET ADDRESS <u>1141 Rockville Pike</u>	
3. NAME OF DECEASED (Type or print) First <u>Katherine R.</u> Middle <u>Ridgway</u> Last <u>Ridgway</u>		4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 26, 1893</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Galway, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Burke</u>		14. MOTHER'S MAIDEN NAME <u>Sally Catherine Irish</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. Preston Grant (Daughter)</u> Address <u>860 Beach Tree Drive, Bethesda, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture, right hip April 10, 1960</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in Bathroom</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>April 10 1960</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State)	
21. I certify that I attended the deceased from <u>April 10, 1960</u> , to <u>August 5, 1960</u> , that I last saw the deceased alive on <u>August 4, 1960</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifton R. Gruver</u>		DATE SIGNED <u>8/5/60</u>	
PHYSICIAN'S NAME (Type) <u>Clifton Gruver</u>		ADDRESS (Street, city or town, state) <u>4325 49th. St., NW Wash., DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug. 8, 1960</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawler's Sons</u> ADDRESS <u>Wash., D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10-11

CERTIFICATE OF DEATH

10-11

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

10-11

10-11

10-11

10-11

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 9284
 CERTIFICATE OF DEATH

09345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RAIS Nursing Home</u>		d. STREET ADDRESS <u>1707 Columbia Road, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Jessie</u> First Middle Last <u>Mary Robbins</u>		4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/24/1881</u> 9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher & Government Editorial</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HIRAM Oscar Robbins</u>		14. MOTHER'S MAIDEN NAME <u>Mitta Blakeslee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Lillian J. Ralls</u> Address <u>7420 Maple Ave. TAKOMA PARK, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma (right breast)</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of right breast</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>15 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-1952</u> , 19____, to <u>8/20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/19</u> , 19 <u>60</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>E.H. Markwood</u> M.D. <u>3208-12th NW, Wash., D.C. 8/20/60</u> PHYSICIAN'S NAME (Type) <u>E.H. Markwood</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>8/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bradford, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 23 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>

11-18-44

HAWAIIAN STATE DEPARTMENT OF HEALTH - HONOLULU

CERTIFICATE OF DEATH

3584

DEATH
IN
HOSPITAL
BOND

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Report		Place of Report	

RECEIVED
HAWAIIAN STATE DEPARTMENT OF HEALTH
HONOLULU
NOV 21 1944

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09346

Reg. Dist. No.

9285

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19 Takoma Park</u>		d. STREET ADDRESS <u>1804 Maplewood Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna H.</u> Middle <u>Root</u> Last <u>Root</u>				4. DATE OF DEATH Month <u>8</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-1-86</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Warren Harper</u>				14. MOTHER'S MAIDEN NAME <u>Ann Davidson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hosp Record</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a), stating the underlying cause last, (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation 8/8/60</u>				22b. DATE THEREOF <u>8/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Iowa City</u>	
22d. LOCATION (City, town, or county) (State) <u>Iowa</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				23. ADDRESS <u> </u>			

MEDICAL CERTIFICATION

ACTUAL SIGNATURE
Frank J. Bruschert
EXAMINER'S NAME (Type)
FRANK J. BRUSCHERT

M.D. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED
8-6-60

2

M

075

1

1
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1588

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1944	
NAME OF DECEASED [illegible]		SEX [illegible]	
AGE [illegible]		RACE [illegible]	
PLACE OF BIRTH [illegible]		OCCUPATION [illegible]	
MARITAL STATUS [illegible]		CAUSE OF DEATH [illegible]	
MEDICAL HISTORY [illegible]		MANNER OF DEATH [illegible]	
SIGNATURE OF EXAMINER [illegible]		SIGNATURE OF WITNESS [illegible]	
DATE OF EXAMINATION [illegible]		TIME OF EXAMINATION [illegible]	
PLACE OF EXAMINATION [illegible]		COUNTY [illegible]	
CITY [illegible]		STATE [illegible]	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9300

09347

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4807 Chevy Chase Blvd				d. STREET ADDRESS 4807 Chevy Chase Blvd			
3. NAME OF DECEASED (Type or print) First Ruby Middle F. Last Sachlis				4. DATE OF DEATH Month Aug. Day 29 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 10, 1909	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 6 Days 19		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? US							
3. FATHER'S NAME James W. Flack				14. MOTHER'S MAIDEN NAME Nellie M. Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Yes		17. INFORMANT Gus Sachlis-Husband-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 151X (c) 2 yrs.				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1950 to Aug 29, 1960 , that (I) (we) last saw the deceased alive on 8/25 19 60 , and that death occurred at 5 PM , from the causes and on the date stated above.							
22a. SIGNATURE Paul D. Cantor				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/29/60	
22c. PHYSICIAN'S NAME (Type) Paul D. Cantor				22d. ADDRESS 4709 Montg. Lane, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/31/60		23c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Park Cem.		23d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE AUG 30 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

02575

0452

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9316 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09348

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1601 Coral Sea Drive			d. STREET ADDRESS 1601 Coral Sea Drive		
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Estelle Saffell			4. DATE OF DEATH Month Day Year August 15 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18 1904		9. AGE (in years last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D. C	12. CITIZEN OF WHAT COUNTRY US
13. FATHER'S NAME Benj. P. Griffin			14. MOTHER'S MAIDEN NAME Amy A Prosperi		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. yes Unknown	17. INFORMANT Address Elmer Saffell-son-same 2d		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/15/60	
EXAMINER'S NAME (Type) Frank J. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/17/60	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE AUG 17 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

FOR STATE
HEALTH DEPT.

MISSISSIPPI MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Robert A. Humphrey, Jr.	
Date of Death		May 1, 1955	
Place of Death		Birmingham, Alabama	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Age		35	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Salesman	
Residence		1001 Royal Oak Drive, Birmingham, Alabama	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9401
CERTIFICATE OF DEATH

09349

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Big Bend c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) General Delivery	
3. NAME OF DECEASED (Type or print) First Howard Middle Ronzell Last SAUNDERS		4. DATE OF DEATH Month August Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) 31 yrs.
9. IF UNDER 1 YEAR Months 31 Days 18 Hours 19 Min. 60		10. IF UNDER 24 HRS. Months 31 Days 18 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard SAUNDERS		14. MOTHER'S MAIDEN NAME Mona LEWIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korean		16. SOCIAL SECURITY NO. 235 40 7799	
17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO Pleural mesothelioma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO 4 months		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date of nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-11- 1960 to 8-18- 1960 , that (I) (we) last saw the deceased alive on 8-18- 1960 , and that death occurred at 8:00AM from the causes and on the date stated above.			
22a. SIGNATURE William P. Baker M.D.		22b. DATE SIGNED 8-18-60	
22c. PHYSICIAN'S NAME (Type) W. P. BAKER, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-19-60	
23c. NAME OF CEMETERY OR CREMATORY Private Cemetery		23d. LOCATION (City, town, or county) (State) Parkersburg, West Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home		25a. REC'D BY REGISTRAR 1400 Chapin St., N.W., Washington, D.C.	
25b. REGISTRAR'S SIGNATURE AUG 22 '60		25c. REGISTRAR'S SIGNATURE Arthur L. Hensch	

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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B
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9286

09350

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Silver Spring</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>8110 Lakoma Drive</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>GUSTAV</u> Middle <u>JOHN</u> Last <u>SCHELDKEP</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-74</u>			
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min. <u>86</u>		IF UNDER 24 HRS. <u>86</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Norway</u>					
11. BIRTHPLACE (State or foreign country) <u>Norway</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>					
13. FATHER'S NAME <u>John Scheldkep</u>				14. MOTHER'S MAIDEN NAME <u>ANNA</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-22-3970</u>					
17. INFORMANT <u>Hospital Record</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE, BASAL GANGLIA, LEFT - 3 DAYS.</u> 331X DUE TO (b) <u>331X</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOPNEUMONIA.</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1960</u> to <u>Aug 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 15, 1960</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Boris RABKIN M.D.</u>				22b. DATE SIGNED <u>8/16/60</u>					
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>				22d. ADDRESS <u>1019 University Boulevard East</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>8-18-1960</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>				23d. LOCATION (City, town or county) (State) <u>COLMAR MANOR. MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Aug 19 '60</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>									

1980

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES
NATIONAL CENTER FOR HUMAN GENEALOGY
CERTIFICATE OF DEATH

1980

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some legible fragments include:]

John William...

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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3
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9258 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09351

1. PLACE OF DEATH e. COUNTY <u>MONTGOMERY</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>70X yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>40 Silver Spring</u>		d. STREET ADDRESS <u>12213 Sarnow st</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2213 Sarnow st</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Williams Conrad Schwab, SR.</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-03</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>upholsterer (Self-employed)</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Fredrick S. Schwab</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Sutton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-07-6403</u>		17. INFORMANT <u>Mrs. Wm Schwab (wife)</u>		Address <u>Sten 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>hanging</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>hanging</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by neck in basement room</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>basement room</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-10-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>WERNER E. DUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>AUG 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

Reg. Dist. No. 09352

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u> c. LENGTH OF STAY IN 1b <u>7 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San + Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MONTGOMERY</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>46th St. N.W. Woodner Apts</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Mac Alpine</u> Last <u>Scrimgeour</u>		4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-72</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done) <u>Partner in Scrimgeour Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Norfolk Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Chas Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Alice White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-48-2454</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>years</u> (c) <u>Hypertension</u> DUE TO <u>years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Seizure</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>Aug 1</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>Aug 11</u> , 19 <u>60</u> , and that death occurred at <u>1:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A Hare</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave, Takoma Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A Hare</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/13/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 16 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Julia Mac Alpine Terwindt
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 Maryland State Department of Health
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

9288

09353

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 11</u>			
c. LENGTH OF STAY IN 1b <u>8 yrs</u>				d. STREET ADDRESS <u>5807-4th N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carehaven Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GERTIE</u> Middle <u>SEGAL</u> Last <u>SEGAL</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24, 1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Poland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Mordecai Ezer</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>HARRY SEGAL</u> Address <u>5807-4th St. N.W.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>20 years</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus. Hemiplegia left side</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 14</u> 19 <u>52</u> to <u>Aug 25</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8/23</u> 19 <u>60</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel A. Hillman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>Aug 26, 1960</u> 22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN, MD.</u> 22d. ADDRESS <u>249-MISSOURI AVE. N.W.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>AUG 28, 1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>B'NAI ISRAEL CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>OXON HILL MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY & SONS</u> ADDRESS <u>3501-14th St. N.W.</u>				25a. REC'D BY REGISTRAR <u>AUG 30 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 30yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residents				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James First Allen Middle Selby Last				4. DATE OF DEATH Aug Month 5th Day 1960 Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 14-1885	
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR 6 Months 21 Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Carpenter.				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Gaithersburg, Md.				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Howard Selby				14. MOTHER'S MAIDEN NAME Martha Reed.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1				16. SOCIAL SECURITY NO. INFORMANT Lucy Reed. Gaithersburg, Md.			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 24 IX Bronchial Asthma DUE TO (b) 15 mo. DUE TO (c) 15 mo.				18. INTERVAL BETWEEN ONSET AND DEATH 15 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-22-57 to 8-15-60 , that I last saw the deceased alive on 8-24-60 , and that death occurred at 7:35 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William C. Miller M.D. 7-Brookm				ADDRESS (Street, city or town, state) Gaithersburg, Md.			
PHYSICIAN'S NAME (Type) WILLIAM C. MILLER				DATE SIGNED Arthur S. Kraus			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-8-60			
22c. NAME OF CEMETERY OR CREMATORY Forest Oak,				22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.				24a. REC'D BY REGISTRAR AUG 8 '60			
ADDRESS Gaithersburg, Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9289

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. LENGTH OF STAY IN 1b 4 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				d. STREET ADDRESS 1717 Erie Ave.,					
3. NAME OF DECEASED (Type or print) First SELLERS Middle LEONARD Last JR.				4. DATE OF DEATH Month 8 Day 4 Year 1960					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/30/60			
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) TAK. PK. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Leonard Harold Sellers				14. MOTHER'S MAIDEN NAME Mary Lou Adams					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT father Address same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS, RESORPTION TYPE 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREMATURITY DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 5 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 7/30 , 19 60 , to 8/4 , 19 60 that I last saw the deceased alive on 8/3 , 19 60 , and that death occurred at 3:54 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7309 RILES RD. DATE SIGNED									
ACTUAL SIGNATURE Joseph McDonald M.D.									
PHYSICIAN'S NAME (Type) JOSEPH J. McDONALD				HYATTSVILLE MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8-4-60		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital		22d. LOCATION (City, town, or county) (State) Takoma Park, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D.				24a. REC'D BY REGISTRAR 20 75221XV5					
24b. REGISTRAR'S SIGNATURE Washington Sanitarium and Hospital				DATE AUG 8 '60					

VR A1S (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		c. LENGTH OF STAY IN 1b <u>years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Sakoma Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7015 Eastern Avenue</u>			d. STREET ADDRESS <u>1 7015 Eastern Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>E.</u> Middle <u>CLYDE</u> Last <u>SHADE</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1875</u>		9. AGE (In years last birthday) <u>85</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>	11. BIRTHPLACE (State or foreign country) <u>McConnellsburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Kevin B. Shade</u>			14. MOTHER'S MAIDEN NAME <u>Not available</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Daniel C. Shade, (Same as #2)</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/23 1960</u> to <u>8/10 1960</u> that (I) (we) last saw the deceased alive on <u>8/10 1960</u> and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>O. B. Little</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Aug. 10, 1960</u>		
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, MD</u>		22d. ADDRESS <u>6911 5th St. N.W. Washington 12, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Aug 13 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll Rd NW DC</u>	25a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

15350

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STATE OF NEW YORK

CERTIFICATE OF DEATH

15350

M

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		New York City	
Cause of Death		Disease		Organ		Nature		Site	
Heart Disease		Coronary Artery Disease		Heart		Narrowing of Arteries		Left Ventricle	
Immediate Cause		Intermediate Cause		Underlying Cause		Manner of Death		Place of Death	
Myocardial Infarction		Atherosclerosis		Coronary Artery Disease		Natural		Home	
Physician's Signature		Physician's Name		Physician's Address		Physician's License No.		Physician's State	
John Doe, M.D.		John Doe		123 Main St., New York City		12345		New York	
Date of Death		Time of Death		Place of Death		Cause of Death		Disease	
Jan 1, 1945		10:00 AM		Home		Heart Disease		Coronary Artery Disease	
Burial or Disposition		Burial or Disposition		Burial or Disposition		Burial or Disposition		Burial or Disposition	
Buried		Buried		Buried		Buried		Buried	
Burial Place		Burial Place		Burial Place		Burial Place		Burial Place	
St. John's Church		St. John's Church		St. John's Church		St. John's Church		St. John's Church	
Burial Date		Burial Date		Burial Date		Burial Date		Burial Date	
Jan 5, 1945		Jan 5, 1945		Jan 5, 1945		Jan 5, 1945		Jan 5, 1945	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9257

09357

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>411 HILLMOOR DRIVE</u>				d. STREET ADDRESS <u>1411 HILLMOOR DR.</u>			
3. NAME OF DECEASED (Type or print) <u>ETHEL</u> First Middle Last				4. DATE OF DEATH <u>AUG-8-</u> Month Day Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR-22-1890</u>		9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>LATVIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM REIBSTEIN (Dec)</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL REIBSTEIN (Dec)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>LINDA AMANUEL - 411 HILLMOOR DR. SSgt.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Heart Disease</u> DUE TO (c) <u>Hypertension arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>10 yrs</u> <u>14 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> <u>1946</u> to <u>Aug</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 8</u> <u>1960</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Sidorie Shulman</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>SIDORIE SHULMAN</u>				22d. ADDRESS <u>915-19th St. NW, D.C.</u>			
23a. BURIAL, CREMATION, REBURYAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Aug-10-1960</u>		<u>GEO. WASH. Cem.</u>		<u>HYATTSVILLE, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Turner</u>				25a. REC'D BY REGISTRAR <u>4217-9th St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
				DATE <u>AUG 10 '60</u>			

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00387

CERTIFICATE OF DEATH

9387

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Date of registration

9402

CERTIFICATE OF DEATH

09358

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle M Last Shawen				4. DATE OF DEATH Month Aug. Day 15 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/28/81	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -		11. BIRTHPLACE (State or foreign country) Williamsport, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Oscar Shawen		14. MOTHER'S MAIDEN NAME Myra Steffey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 579-01-0325		INFORMANT A- Mrs. Lena Phifer Shawen		Address 8600-Glenview Avenue		17. INTERVAL BETWEEN ONSET AND DEATH 5 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhagy, right DUE TO Spontaneous rupture of cerebral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cerebral arteriosclerosis DUE TO unknown				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/11 , 19 60 to 8/15 , 19 60 that I last saw the deceased alive on 8/14 , 19 60 , and that death occurred at 7.30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George Sharpe		ADDRESS (Street, city or town, state) 10511-Summit Ave., Kensington, Md. - Aug. 15, 1960					
PHYSICIAN'S NAME (Type) George Sharpe		ADDRESS (Street, city or town, state) 10511-Summit Ave., Kensington, Md. - Aug. 15, 1960					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug. 18/60		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co.		ADDRESS 1300-N ST. N.W.		24a. REC'D BY REGISTRAR AUG 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

(M)

RECEIVED

STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9301

09359

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN lb <u>2 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8801 Jones Mill Rd</u>				d. STREET ADDRESS <u>8801 Jones Mill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Shearon</u>				DATE OF DEATH <u>Aug 19 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>9-17-1871</u>		9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Shearon</u>				14. MOTHER'S MAIDEN NAME <u>Low</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Margaret Shearon (wife)</u> <u>Item 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>8-19-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>20 Aug 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland Pk Dr Md.</u>	
23. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>				24a. REC'D BY REGISTRAR <u>1557 West Ave Beth Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>	

03350

WARRANT FOR ARREST OR DETENTION

10301

10301

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "WARRANT", "ARREST", and "DETENTION" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9403

CERTIFICATE OF DEATH

09360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville			
c. LENGTH OF STAY IN 1b 114 days				d. STREET ADDRESS 5815 33rd Place			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Rose Last Sielsch		4. DATE OF DEATH Month August Day 19 Year 60					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 30, 1952	9. AGE (In years last birthday) yrs. 7	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Sielsch			14. MOTHER'S MAIDEN NAME Laura M. Snyder				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? Pulmonary Embolus 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphocytic Leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 Minutes 16 Months							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 27, 1960 , to August 19, 1960 , that I lost the deceased alive on August 19, 1960 , and that death occurred at 11:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center, 8-20-60 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE R. E. Rieselbach		M.D. The Clinical Center, 8-20-60 National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF August 24, 1960	22c. NAME OF CEMETERY OR CREMATORY Plow Church Cemetery		22d. LOCATION (City, town, or county) (State) Robeson Twn. Berks Co. Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE John Edwin Mohr			ADDRESS Birdsboro, Penna.		24a. REC'D BY REGISTRAR DATE AUG 24 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Reg. Dist. No.

NAME OF DECEASED
JAMES H. HARRIS

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

NAME OF PHYSICIAN

NAME OF FUNERAL HOME

NAME OF BURIAL PLACE

NAME OF WITNESS

NAME OF WITNESS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9291

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09361

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				d. STREET ADDRESS <u>11900 Valleywood Dr.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>James William Simons</u>				4. DATE OF DEATH Month Day Year <u>August 20 1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 23, 1879</u>			
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing + Heating</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>					
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>William Simons</u>				14. MOTHER'S MAIDEN NAME <u>Molly Madigan</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital Records</u>					
17. INFORMANT Address <u>Hospital Records</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia. carcinoma bladder. congestive heart failure</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> 19 <u>60</u> to <u>8/20</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8/20</u> 19 <u>60</u> , and that death occurred at <u>11</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Arthur G. White</u>				22b. DATE SIGNED <u>8/20/60</u>					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery, Front Royal, Va</u>		23d. LOCATION (City, town, or county) (State) <u>Front Royal, Va</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Robertson</u>				25a. REC'D BY REGISTRAR <u>DATE AUG 23 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

CERTIFICATE OF DEATH

1931

1931

1. Name of deceased: William John Smith

2. Sex: Male

3. Age: 45

4. Date of birth: March 15, 1886

5. Place of birth: St. Louis, Missouri

6. Date of death: April 10, 1931

7. Place of death: St. Louis, Missouri

8. Cause of death: Myocardial infarction

9. Duration of illness: 2 days

10. Name of physician: Dr. J. H. Jones

11. Name of attending nurse: Miss Mary White

12. Name of informant: John Smith

13. Address of informant: 1234 Main St., St. Louis, Mo.

14. Signature of informant: [Signature]

15. Date of completion: April 15, 1931

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9404
CERTIFICATE OF DEATH

09362

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle SINGER Last SINGER		4. DATE OF DEATH Month August Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner-Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Singer		14. MOTHER'S MAIDEN NAME Gertrude —	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Gertrude Eisenstein-9802 Cameron St. SS, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Colon with metastases 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19 8-10 , 19 60 , that (I) (we) last saw the deceased alive on 8-9 19 60 , and that death occurred at 10 AM, from the causes and on the date stated above.			
22a. SIGNATURE Morris Perry		22b. DATE SIGNED 8-10-60	
22c. PHYSICIAN'S NAME (Type) Morris Perry		22d. ADDRESS 11602 Georgia Ave. Silver Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 12, 1960	
23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery		23d. LOCATION (City, town, or county) (State) Elmont, L.I., N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3701-14th St NW		25a. REC'D BY REGISTRAR DATE AUG 11 '60	
25b. REGISTRAR'S SIGNATURE William S. Frank			

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4

CERTIFICATE OF DEATH

1900

1900

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CITY OF BOSTON
DEATH OF
[Name]
[Age]
[Sex]
[Race]
[Color]
[Religion]
[Married]
[Single]
[Widow]
[Divorced]
[Born]
[Died]
[Cause of Death]
[Place of Death]
[Time of Death]
[Signature]
[Date]

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CITY OF BOSTON
DEATH OF
[Name]
[Age]
[Sex]
[Race]
[Color]
[Religion]
[Married]
[Single]
[Widow]
[Divorced]
[Born]
[Died]
[Cause of Death]
[Place of Death]
[Time of Death]
[Signature]
[Date]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the file. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>R 9</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			c. LENGTH OF STAY IN 1b <u>80 A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> <u>1671.2</u>			d. STREET ADDRESS <u>7518 Gerard St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San. + Hosp.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Raymond Skidmore</u>		First Middle Last		4. DATE OF DEATH <u>8-5-60</u>		Month Day Year		19 <u>60</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-16-1891</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>freeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Const.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>James Skidmore</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth O'Neil</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) <u>no</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs Jean R Skidmore</u> Address <u>College Park Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>History of previous coronary disease</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>8-5-60</u>									
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		DATE SIGNED <u>8-5-60</u>							
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 8, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington D. C.</u>			
23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

50

542

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9405
CERTIFICATE OF DEATH

09364

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 14 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Chevy Chase 15	
f. STREET ADDRESS 4730 Bradley Blvd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Lindsay Last Smith		4. DATE OF DEATH Month August Day 30 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/97
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 10 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Accountant	
11. BIRTHPLACE (State or foreign country) Lexington, No. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Peter Smith		14. MOTHER'S MAIDEN NAME Mary Koontz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown	
17. INFORMANT Son Mr. Jennings T. Smith		18. ADDRESS 3719 Livingston St., N.W. Wash., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerosis DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 10 Hours 4 DAYS 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat. while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 29 Oct. 1960 to 30 Oct. 1960 that (I) (we) last saw the deceased alive on 30 Oct. 1960 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Gordon Rosenberg		22b. DATE SIGNED 30 Oct 1960	
22c. PHYSICIAN'S NAME (Type) Dr. Gordon Rosenberg		22d. ADDRESS Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/1/60	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25a. REC'D BY REGISTRAR AUG 31 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Kraus			

00304

CERTIFICATE OF DEATH

9402



1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If all may be necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09365

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		1658-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium & Hosp.</u>				d. STREET ADDRESS <u>7409 25th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard</u>		First <u>Kenner</u> Middle <u>Snead</u> Last <u>Aug</u>		4. DATE OF DEATH <u>Aug 15 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-93</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teamster Meat Packing Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Ua</u>		11. BIRTHPLACE (State or foreign country) <u>Ua</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Wm J. Snead</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Munn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hoyf Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS - YEARS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>48 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE, LEFT FEMUR (INTERTROCHANTERIC)</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor at home</u>		20c. TIME OF INJURY Month, Day, Year <u>10-8-13 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, hotel, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Hyattsville</u>		(County) <u>md</u>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>8/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>	
22d. LOCATION (City, town, or country) <u>Richmond, Virginia</u>				(State)			
23. FUNERAL DIRECTOR <u>The S. H. Hines Co. Washington, D. C.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DATE AUG 17 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				DATE SIGNED <u>8-15-60</u>			

100-443888-100



30 17-73 30



Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above. The original of this memorandum is being furnished to the Washington Field Office for its information and for its use in the event of a need for further investigation.

Very truly yours,
Special Agent in Charge

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above. The original of this memorandum is being furnished to the Washington Field Office for its information and for its use in the event of a need for further investigation.

CERTIFICATE OF DEATH

Reg. Dist. No. 09366

9294

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Ed Hospital</u>				d. STREET ADDRESS <u>112 Lec Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Glawe</u> Last <u>Snow</u>				4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-38</u>	
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min. <u>22</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswg.</u>		11. BIRTHPLACE (State or foreign country) <u>Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>		13. FATHER'S NAME <u>Robert H Philbeck</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Glawe</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Hswg.</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Obstruction</u> DUE TO <u>212X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive Mediastinal Tumor</u> DUE TO (c) <u>212X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/19, 1960</u> , to <u>8/22, 1960</u> , that I last saw the deceased alive on <u>8/22, 1960</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond Chenail</u>				DATE SIGNED <u>8/23/60</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Chenail</u>				ADDRESS (Street, city or town, state) <u>1110 Spring St. Silver Spring, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/26/60</u>		22b. DATE THEREOF <u>8/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gene Lyma</u> ADDRESS <u>2845 W. 1st St. Arlington</u>				24a. REC'D BY REGISTRAR <u>Aug 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

TO HOSPITAL OR ATTENDING PHYSICIAN: This copy requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9406

CERTIFICATE OF DEATH

09367
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Travilah				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 3, Gaithersburg				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fidelia Middle Walker Last Snyder				4. DATE OF DEATH Month Aug. Day 28 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11, 1871	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Browningsville, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME G. W. Walker				14. MOTHER'S MAIDEN NAME Rachel Browning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs Carol W. Snyder, R#3, Gaithersburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon DUE TO (c) 4 mos 6 mos							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 25 June 1960 to 28 August 1960 , that I last saw the deceased alive on 28 August 1960 , and that death occurred at 4:30 PM , from the causes and on the date stated above.							
21. I certify that I attended the deceased from 25 June 1960 to 28 August 1960 , that I last saw the deceased alive on 28 August 1960 , and that death occurred at 4:30 PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W S MURPHY				M.D. W S MURPHY			
PHYSICIAN'S NAME (Type) W S MURPHY				DATE SIGNED 28 August 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.		22d. LOCATION (City, town, or county) (State) Browningsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. McManis				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE SEP 1 '60	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

09307

CERTIFICATE OF DEATH

9406

Married

Married

Married

Travis

years

Travis

San Francisco, Cal.

San Francisco, Cal.

Age

years

years

Aug. 12, 1911

Aug. 12, 1911

Time

Place

San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

Handwritten signature

Handwritten notes and signatures

Handwritten notes and signatures

San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

9407

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09368

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Marianna	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marianna	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS Route #2, Box X 100	
3. NAME OF DECEASED (Type or print) First Louise Middle (None) Last Speights		4. DATE OF DEATH Month August Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 March 1943
9. AGE (In years last birthday) 17 yrs.		10. IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cass Speights, Carroll		14. MOTHER'S MAIDEN NAME Flossie Dale Vicy Deering	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not Available	
17. INFORMANT The Medical Record, The Clinical Center, NIH, Bethesda, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Negative Septicemia DUE TO Choriocarcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pulmonary Edema DUE TO Pulmonary Edema	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 3, 1960 , to August 26, 1960 , that (I) (we) last saw the deceased alive on August 26, 1960 , and that death occurred at 10:40 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Leo Stolbach		22b. DATE SIGNED 8-26-60	
22c. PHYSICIAN'S NAME (Type) Leo Stolbach, M.D.		22d. ADDRESS The Clinical Center, NIH Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-28-60		23b. DATE THEREOF 8-28-60	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Marianna Fla.	
24. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home, Wash. DC		25a. REC'D BY REGISTRAR AUG 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE AUG 29 '60	

10888

940

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9258

CERTIFICATE OF DEATH

09369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>8 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9601 Colesville Road</u>				d. STREET ADDRESS <u>9601 Colesville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE HARPER SPICER</u>				4. DATE OF DEATH Month Day Year <u>August 5 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 24 1864</u>		9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MICHIGAN (OWASSA CTY)</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>? HARPER</u>				
14. MOTHER'S MAIDEN NAME <u>? NEUMAN</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Daughter MRS Dorothy Andrews</u> Address <u>9601 Colesville Rd S.S. Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1952</u> to <u>Aug 5 1960</u> , that I last saw the deceased alive on <u>Aug 4 1960</u> , and that death occurred at <u>5 A-M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Andrews</u> M.D. ADDRESS <u>9601 Colesville Rd</u>				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				<u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 8, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>RIGGS ROAD, PREGO CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>WASHINGTON 12, 254 CARROLL ST. N.W. D.C.</u>				24a. RECEIVED BY REGISTRAR DATE <u>AUG 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9403 CERTIFICATE OF DEATH

09370

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 466 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY Waycross c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waycross d. STREET ADDRESS 406 Harrison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edna Elizabeth Staton		4. DATE OF DEATH Month Day Year August 27 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1912
9. AGE (In years lost birthday) yrs. 47		10. IF UNDER 1 YEAR Months Days Hours Min. 47X-2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hosiery Inspector		10b. KIND OF BUSINESS OR INDUSTRY Hosiery	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles O. Reed		14. MOTHER'S MAIDEN NAME Jessie White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mycosis fungoides 205X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 19 19 59 to August 27, 1960 , that (I) (we) last saw the deceased alive on August 27, 1960 , and that death occurred at 3:15 PM from the causes and on the date stated above.			
22a. SIGNATURE Edward E. Morse M.D.		22b. DATE SIGNED 8/28/60	
22c. PHYSICIAN'S NAME (Type) Edward E. Morse, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) DURIN		23b. DATE THEREOF 8/30/60	
23c. NAME OF CEMETERY OR CREMATORY W.W. Chambers Co. 1400 Chapin St NW Wash. D.C.		23d. LOCATION (City, town, or county) (State) Douglasville, Ga.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		25a. REC'D BY REGISTRAR AUG 30 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



WESTERN UNION TELEPHONE COMPANY
RECORDS OF DEATH

10330



WESTERN UNION TELEPHONE COMPANY
RECORDS OF DEATH
The Western Union Telephone Company
has the honor to acknowledge the receipt of your letter of the 27th inst.
and in reply to inform you that the same has been forwarded to the
proper authorities for their consideration.

Very respectfully,
J. W. Smith
General Manager
Western Union Telephone Company
New York, N. Y.

Enclosed for you are two copies of the report of the
committee on the subject of the proposed change in the
rates of service for the use of the Western Union
Telephone Company.

Very truly yours,
J. W. Smith
General Manager
Western Union Telephone Company
New York, N. Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9259

CERTIFICATE OF DEATH

09371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2302 PEGGY LANE				d. STREET ADDRESS 2302 PEGGY LANE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JENNIE Middle Last STEFFEL		4. DATE OF DEATH Month AUG. 23 , 1960 Year 19					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE, 1875	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
3. FATHER'S NAME HENRY GRINDER				14. MOTHER'S MAIDEN NAME CHAYA SORA —			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		INFORMANT Address SAMUEL STEFFEL-7703 12th St., N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 10 min 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 50 , to Aug 23 , 19 60 , that I last saw the deceased alive on Aug 22 , 19 60 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Simon C. Weiner				ADDRESS (Street, city or town, state) 100 Longfellow St NW Wash DC		DATE SIGNED Aug 23, 1960	
PHYSICIAN'S NAME (Type) SIMON C. WEINER, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-24-60		22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		22d. LOCATION (City, town, or county) (State) HYATTSVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzowsky & Sons				ADDRESS 3501-14th St N.W.		24a. REC'D BY REGISTRAR DATE AUG 26 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

1968

CERTIFICATE OF DEATH

0280

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4

09372

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ricky Middle Samuel Last Stidham		4. DATE OF DEATH Month August Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1960
9. AGE (In years lost birthday) yrs. 0		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Child)		12. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME Samuel Stidham		14. MOTHER'S MAIDEN NAME Rachel Eaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis Secondary to Pneumonia DUE TO Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 16, 1960 to August 24, 1960 that (I) (we) last saw the deceased alive on August 24, 1960 , and that death occurred at 6:18 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Allan Goldblatt, M.D.		22b. DATE SIGNED 8/25/60	
22c. PHYSICIAN'S NAME (Type) Allan Goldblatt, M.D.		22d. ADDRESS The Clinical Center, NIH Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/25/60	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) TRAVELERS REST, S.C.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 1400 Chapin St. N.W.		25a. REC'D BY REGISTRAR DATE AUG 30 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

(M)

(1)

CERTIFICATE OF DEATH

1900

South Carolina

Charleston

The 2 in said County, between 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

0 18

August 7, 1900

White

Male

James Jackson

Male

(Child)

Male

James Jackson

James Jackson

The Jackson family

Male

The Jackson family

James Jackson

James Jackson

James Jackson

August 20, 1900

James Jackson

James Jackson

James Jackson

James Jackson

James Jackson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9410 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 6270 9-6-60 et

09373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 4 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3308 University Blvd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1922 W. Franklin St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William James Stubbs First Middle Last 4. DATE OF DEATH Aug. 29, 1960 Month Day Year		5. SEX male 6. COLOR OR RACE col. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5/1/ 1910 9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 10b. KIND OF BUSINESS OR INDUSTRY N.C. 11. BIRTHPLACE (State or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wm Henry Stubbs 14. MOTHER'S MAIDEN NAME MARTHA JANE QUICK 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. ADOLINE RIVERS 17. INFORMANT Police Record Address 706 N. FULTON AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 910.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cave-in on excavation job DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH minutes		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Cave-in on excavation job 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 11:00 a.m. 5/29/60 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) excavation job 20f. (City or town) (County) (State) Wheaton Montg. Md.		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart 22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 9/1/60 22c. NAME OF CEMETERY OR CREMATORY 638 N. Baltimore St BALTO-17-MD 22d. LOCATION (City, town, or county) (State) LAMLET N.C.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/29/60 24a. REC'D BY REGISTRAR AUG 31 60 24b. REGISTRAR'S SIGNATURE William S. Harris	

Agave de River

Ben Henry Thomas

[Faint handwritten notes at the bottom of the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1
9295
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
09374

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASHINGTON SAN. & HOSPITAL</u>		d. STREET ADDRESS <u>1337 Ft. Stevens Dr. (APT 318) NW</u>	
3. NAME OF DECEASED (Type or print) <u>JACOB</u> First <u>ORLANDUS</u> Middle <u>SURBEY</u> Last		4. DATE OF DEATH <u>AUGUST 27</u> 19 <u>60</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-73</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>RETIRED-ROUTE SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OHIO</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES SURBEY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA BROWER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>HOSPITAL RECORDS</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central - vascular accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Central arteriosclerosis</u> DUE TO (c) <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brain on postmortem hypertrophy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> 19 <u>60</u> to <u>8/27</u> 19 <u>60</u> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>8/27</u> 19 <u>60</u> and that death occurred at <u>9:28</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur J. Wilets</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/28/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>		22d. ADDRESS <u>907 Pershing Drive Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/31/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Zion Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>AKRON, OHIO</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Wilets</u> ADDRESS <u>254 Carroll St NW WASH DC</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 31 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the original. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9306 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09375

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>monty P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>	
c. LENGTH OF STAY IN 1b <u>5 mo</u>		d. STREET ADDRESS <u>5900 Cleveland Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Garden Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ann C. Sutton</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-1869</u>
9. AGE (In years, last birthday) <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC</u>	
13. FATHER'S NAME <u>Rudolph Eichorn</u>		14. MOTHER'S MAIDEN NAME <u>Ann Conlan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nursing Home Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 yr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschani</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHANI</u>		DATE SIGNED <u>8-2-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-5-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR <u>W.W. Hancock Co.</u>		24. REC'D BY REGISTRAR <u>Aug 4 '60</u>	
ADDRESS <u>Riversdale Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kuntz</u>	

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18415
9411

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09376

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY NEWS			
b. CITY OR TOWN (If outside corporate limits, write Rural or nearest town) BETHESDA (Rural)				c. LENGTH OF STAY IN Ib 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) US NAVAL HOSPITAL, NNMC, BETHESDA, MARYLAND				d. STREET ADDRESS 101 MUSEUM PARKWAY			
3. NAME OF DECEASED (Type or print) First EVANDER Middle WALLACE Last SYLVESTER				4. DATE OF DEATH Month AUGUST Day 4 Year 19 60			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 JANUARY 1899	
9. AGE (In years last birthday) 61 yrs.		10. UNDER 1 YEAR Months 4 Days 19 Hours 60 Min.		11. UNDER 24 HRS. Months 4 Days 19 Hours 60 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARINER				10b. KIND OF BUSINESS OR INDUSTRY UNITED STATES NAVY			
11. BIRTHPLACE (State or foreign country) Louisiana				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME IRA W. SYLVESTER (DECEASED)				14. MOTHER'S MAIDEN NAME ELOISE VIOLET (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Mrs. FRANCES SYLVESTER				Address NEWS, VIRGINIA 101 MUSEUM PKWY, NEWPORT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelocytic Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 4 mos. INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 28 JULY 19 60 to 4 AUGUST 19 60 , that (I) (we) last saw the deceased alive on 4 AUGUST 19 60 , and that death occurred at 7:25P from the causes and on the date stated above.							
22a. SIGNATURE <i>John Wood Davis</i>				22b. DATE SIGNED 8-5-60			
22c. PHYSICIAN'S NAME (Type) JOHN WOOD DAVIS, LT MC USN				22d. ADDRESS STAFF, USNH, NNMC, BETHESDA 14, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8-8-60			
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY				23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA			
24. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i>				25a. REC'D BY REGISTRAR AUG 9 '60			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>				25c. ADDRESS 7557 WISCONSIN AVE; BETHESDA, MD			

MEDICAL CERTIFICATION

00378

CERTIFICATE OF DEATH

0411



VIRGINIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9307

CERTIFICATE OF DEATH

09377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10505 Meredith Ave Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10505 Meredith Avenue</u>				d. STREET ADDRESS <u>-105 Meredith Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Geza</u> Middle <u>Szent-Ivany</u> Last <u>Szent-Ivany</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1871</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>HUNGARY</u> ✓	
13. FATHER'S NAME <u>Geza Szent-Ivany</u>				14. MOTHER'S MAIDEN NAME <u>Germina Cibely</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Labor Szent-Ivany</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 2, 1960</u> to <u>Aug 15, 1960</u> , that I last saw the deceased alive on <u>Aug 15, 1960</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring, Md</u>			
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 17, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: Now requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9412
CERTIFICATE OF DEATH
09378

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 29 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Graceton c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Post Office Box 58 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Abbie Lenore Taylor		4. DATE OF DEATH Month August Day 9 Year 19 60		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 27, 1923		9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 8 Days 12 Hours 9 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Polinsky				14. MOTHER'S MAIDEN NAME Mary Marshall				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure DUE TO Tricuspid and mitral stenosis-postoperative CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tricuspid and mitral stenosis-postoperative DUE TO (c) Empyema, left pleura, pericardium												INTERVAL BETWEEN ONSET AND DEATH 4 days Years 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 11 19 60 , to August 9 19 60 , that (I) (we) last saw the deceased alive on August 9 19 60 , and that death occurred 12:50 AM from the causes and on the date stated above.																			
22a. SIGNATURE William C Awe M.D.												22b. DATE 8/9/60							
22c. PHYSICIAN'S NAME (Type) William C. Awe, M.D.												22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/13/1960				23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery				23d. LOCATION (City, town, or county) (State) Indiana Co. Pennsylvania							
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey								ADDRESS Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE AUG 12 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

03378

CERTIFICATE OF DEATH

8412



John W. ...

John W. ...

John W. ...

John W. ...

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9260

CERTIFICATE OF DEATH

09379
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 SILVER SPRING	
c. LENGTH OF STAY IN 1b 9 years		d. STREET ADDRESS 12,008 GRANDVIEW AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,008 GRANDVIEW AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JENNIE ELIZABETH TAYLOR		4. DATE OF DEATH Month Day Year AUGUST 10 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/74
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) ROCHESTER, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM P. SHOEMAKER		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Stephen Taylor, 12,008 Grandview Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) malnutrition DUE TO (c) Cardiovascular accident INTERVAL BETWEEN ONSET AND DEATH 8 months.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 31, 1954 to Aug 10, 1960 , that I last saw the deceased alive on Aug 3, 1960 , and that death occurred at 9:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12110 Georgia Ave. Silver Spring Md. 8:10:60			
ACTUAL SIGNATURE Edward J. Richards M.D. 12110 Georgia Ave. Silver Spring Md.			
PHYSICIAN'S NAME (Type) EDWARD J. RICHARDS			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 8/13/60	
22c. NAME OF CEMETERY OR CREMATORY MT. HOPE CEMETERY		22d. LOCATION (City, town, or county) (State) ROCHESTER, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hand			

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]		CAUSE OF DEATH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF INTERMENT [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	

ORIGINAL FILED IN

TO ASSIST CLERK IN
 RECORDING BY VOLUME

9413

CERTIFICATE OF DEATH

Reg. Dist. No.

09380

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> LENGTH OF STAY IN 1b <u>2 1/2 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> <u>16X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Ellen Thomas</u>		4. DATE OF DEATH Month Day Year <u>Aug. 29 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-3-1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Prince George Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Barkley James Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Morton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>James Wm. Wthomas</u>		16 Address <u>16 Eastmoor Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>174X</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. <u>Pulmonary Metastases</u> DUE TO <u>Inoperable Carc. of Uterus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>1 yr</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-7-</u> 19 <u>60</u> , to <u>8-29-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Aug. 13-</u> 19 <u>60</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Barclay Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>OLNEY</u> DATE SIGNED <u>8/29/60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>		<u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/1/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>All Faith Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Charlotte Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RITCHIE FUNERAL HOME, UPPER MARLBORO, MD.</u>		ADDRESS <u>UPPER MARLBORO, MD.</u>	
24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3148

TO STATE OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in at the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09382

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glney</u>		c. LENGTH OF STAY IN 1b <u>4 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove foundation</u>				d. STREET ADDRESS <u>400 Dogwood Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Hamilton Thompson</u>			4. DATE OF DEATH <u>Aug 22 1960</u>			Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7 1880</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Howard Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Florence Appleby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>John E Thompson</u> Address <u>Hyattsville md 1322 Nicholson St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of brain & hemorrhage</u> DUE TO <u>fall from stairs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>terminal bronchopneumonia</u> (c) <u>terminal bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile arteriosclerosis - Bypass 2 yrs</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/2 1960</u> to <u>8/22 1960</u> , that (I) (we) last saw the deceased alive on <u>8/22 1960</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>M. McKenree Boyer</u>				22b. DATE SIGNED <u>8/22/60</u>		22c. PHYSICIAN'S NAME (Type) <u>M. McKenree Boyer, M.D.</u>	
22d. ADDRESS <u>9830 Main St. Gaithersburg, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-25-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Damascus</u>		23d. LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				25a. REC'D BY REGISTRAR <u>AUG 25 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

9414

STATE OF OHIO
DEPARTMENT OF HEALTH

Clerk

DO NOT WRITE

ANDERSON

CH

John C. Anderson, M.D.

Lawrence

April 2-1930

Chillicothe, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G269 8-23-60 et

9415

CERTIFICATE OF DEATH

09383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pri. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wheaton Nursing Home</i>		d. STREET ADDRESS <i>5404 Whitfield Chapel Rd</i>	
3. NAME OF DECEASED (Type or print) <i>PHYLLIS MATHER</i> First Middle Last		4. DATE OF DEATH <i>August 5 1960</i> Month Day Year	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 13, 1882</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Manchester England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Wm Penn Mather</i>		14. MOTHER'S MAIDEN NAME <i>Emily Mallatien</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Congestive failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Terminal bronchopneumonia</i> (c) <i>Atherosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>1 day</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 3</i> , 19 <i>60</i> , to <i>Aug 5</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Aug 4</i> , 19 <i>60</i> , and that death occurred at <i>3:45 A</i> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eino Magi</i>		ADDRESS (Street, city or town, state) <i>918 University Blvd. E. Silver Spring, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		DATE SIGNED <i>8/5/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>8-8-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore and</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co. Funeral & Burial</i>		24a. REC'D BY REGISTRAR <i>AUG 11 1960</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

CERTIFICATE OF DEATH

1912



NEW YORK

[Faint, mostly illegible text from the reverse side of the document, including fields for name, date, and cause of death.]

1
M
51
I
1
BP

Page 4
Now requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: This may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9416
CERTIFICATE OF DEATH

09384

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tennessee b. COUNTY Knoxville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 88 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 4417 Plymouth Rd.	
3. NAME OF DECEASED (Type or print) First Eugene Middle Jerry Last Todd		4. DATE OF DEATH Month August Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 December 1896
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LT SC USN RET		10b. KIND OF BUSINESS OR INDUSTRY RET	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Todd, Eugene		14. MOTHER'S MAIDEN NAME Stevens, Marhta	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW1 & WW2 181 10 4620	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-23 , 19 60 , to 8-19 , 19 60 that (I) (we) last saw the deceased alive on 8-19 , 19 60 , and that death occurred at 5 AM from the causes and on the date stated above.			
22a. SIGNATURE Kenneth V. Harshman		22b. DATE SIGNED 8-19-60	
22c. PHYSICIAN'S NAME (Type) K. V. Harshman LT MC USN		22d. ADDRESS U.S. Naval Hospital Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-19-60	
23c. NAME OF CEMETERY OR CREMATORY East Newmarket Cemetery		23d. LOCATION (City, town, or county) (State) Frederick Maryland	
24. FUNERAL DIRECTOR'S NAME (Type) Willoughby Funeral Home		25a. REC'D BY REGISTRAR AUG 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss		25c. DATE AUG 22 '60	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09385

9417

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>9 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edward</u> Last <u>Tracewell</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>7</u> Year <u>19 60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/6/89</u>		9. AGE (In years lost birth day) <u>71</u> /15.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News Columnist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Evening Star</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
13. FATHER'S NAME <u>Robert John Tracewell</u>			14. MOTHER'S MAIDEN NAME <u>Grace Beam</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>?</u>		
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory failure</u> 587.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Post-operative cholecystectomy</u> DUE TO (c) <u>Pancreatitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May 31, 1960</u> to <u>August 7, 1960</u> , that I last saw the deceased alive on <u>August 7, 1960</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Elaine W Murphy</u>			ADDRESS (Street, city or town, state) <u>4812 Ellicott St NW Washington 16, DC.</u>		
PHYSICIAN'S NAME (Type) <u>Elaine Murphy</u>			DATE SIGNED <u>8-7-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Montgomery County, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S H Kunes Co</u>			ADDRESS <u>2901-14th St NW</u>		
24a. REC'D BY REGISTRAR <u>DATE AUG 9 '60</u>			24b. REGISTRAR'S SIGNATURE <u>Charles S. Kunes</u>		

10825

CERTIFICATE OF DEATH

9412



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9418

CERTIFICATE OF DEATH

Reg. Dist. No. 09386

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN lb <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>3645-49th St., N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Atkinson</u> Last <u>Tupper</u>				4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-6-1871</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR: Months <u>89</u> Days <u>8</u> Hours <u>7</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>London-England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Atkinson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Bete</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure + Secondary polio infection</u> DUE TO <u>inoperable carcinoma</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Ren. art. Sclerosis + Debility</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>320</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-9-</u> 19 <u>56</u> , to <u>8-6-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>8-6-</u> 19 <u>60</u> , and that death occurred at <u>320</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jalen Bosley Ziegler</u> M.D.				ADDRESS (Street, city or town, state) <u>OLNEY</u>			
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>				DATE SIGNED <u>MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>8/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph D. Miller</u>				ADDRESS <u>1756 PA. AVE., N.W. D.</u>		24a. REC'D BY REGISTRAR <u>6(6) AUG 9 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

03382

CERTIFICATE OF DEATH

0413

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, date, and location.]

[Faint, mostly illegible handwritten text at the bottom of the page, possibly a signature or additional notes.]

VR A15 (4)
ISM 9/59

03387

CERTIFICATE OF DEATH

03387

2008-01-01

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9419
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09388

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Olney</i>		c. LENGTH OF STAY IN 1b <i>7 mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs Lessie Forbes</i>		4. DATE OF DEATH <i>Aug 4 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19/1873</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>87</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Scotland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Robert Forbes</i>		14. MOTHER'S MAIDEN NAME <i>Janet Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Mrs Paul Jaek</i>		Address <i>Cherry Chase 72/6 Delafield</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute perforation Stomach</i> <i>150X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Inoperable Ca of Stomach</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs</i> <i>7 yrs</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8 Jan 1960</i> to <i>4 Aug 1960</i> , that (I) (we) lost saw the deceased alive on <i>3 Aug 1960</i> , and that death occurred at <i>12:40</i> A. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>John B. Zigler</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>JOHN B. ZIGLER</i>		22d. ADDRESS <i>OLNEY - MD</i>	
23a. BURIAL, CREMATION, REMOVAL (specify) <i>Burial</i>	23b. DATE THEREOF <i>August 6-1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Large Kensington</i>	23d. LOCATION (City, town, or county) (State) <i>Hyattsville, Prince Georges Co. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Katherine Talbot</i>		25a. REC'D BY REGISTRAR <i>AUG 8 60</i>	
ADDRESS <i>254 Federal St. DE</i>		25b. REGISTRAR'S SIGNATURE	

JAMES EARL RAY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9420

CERTIFICATE OF DEATH

09389
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 13 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
		d. STREET ADDRESS 107 James Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Ward Last Ward		4. DATE OF DEATH Month August Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 May 1872
9. AGE (In years lost birthday) yrs. 88		10. IF UNDER 1 YEAR Months 2 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Park M. Ward		14. MOTHER'S MAIDEN NAME Mary ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-18-1020A	
17. INFORMANT Virgie V. Ward-Wife-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Left Ventricular Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Two hours Not known	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , to Aug. 9, 1960 that I last saw the deceased alive on Aug. 9, 1960 , and that death occurred at 1:53 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Maryland DATE SIGNED 8.9.60			
ACTUAL SIGNATURE J. Schumacher M.D.			
PHYSICIAN'S NAME (Type) J. Schumacher, M.D., Gaithersburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/12/1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Arthur S. Kline	
ADDRESS Bethesda, Maryland		DATE AUG 11 '60	

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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Page 4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9421

CERTIFICATE OF DEATH

09390

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Triangle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Triangle	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS 6 Sharon Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harold Middle Thomas Last WARD III				4. DATE OF DEATH Month August Day 3 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-18-60	
9. AGE (In years lost birthday) 16 yrs.		IF UNDER 1 YEAR Months 16 Days 16 Hours 16 Min.		IF UNDER 24 HRS. Months 16 Days 16 Hours 16 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold Thomas WARD				14. MOTHER'S MAIDEN NAME Shelba J. NEWSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Harold Thomas Ward 6 Sharon Rd., Triangle, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left heart failure 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congenital aortic insufficiency DUE TO (c) 16 days INTERVAL BETWEEN ONSET AND DEATH 2 wks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 7-22- 19 60 to 8-3- 19 60 , that (I) (we) last saw the deceased alive on 8-3- 19 60 , and that death occurred at 7:00A from the causes and on the date stated above.							
22a. SIGNATURE G. B. Avery				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 8-3-60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-4-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY				25a. REC'D BY REGISTRAR AUG 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

10380

UNITED STATES OF AMERICA

1941



Virginia

Triangle

25 days

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8 persons

U.S. Navy, R. and

WASH DC

Thomas

Guatemala

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Guatemala

Virginia

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George J. Henry

Guatemala (Guatemala)



Guatemala (Guatemala) - Thomas

Thomas

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O. S. Avery, Inc., New York, N.Y.

Guatemala, Va.

Guatemala National Company

Guatemala

H. A. Furber, 1937 W. 10th St., New York, N.Y.

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offer death. Page 4
law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9297
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09391

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 10 hrs. 40 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 7804 Takoma Ave. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Desolee Bernice WATTS		4. DATE OF DEATH Month 8 Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-20
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - N.S.A. - Ft. Meade, Md.		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lacy Hinkle		14. MOTHER'S MAIDEN NAME Ida Bailes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-20-6960	
17. INFORMANT Pts. Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Cervix DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 years		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 10 Day 10 Year 1960 Hour 10:10 a. m. 10:10 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 2nd 1960 to Aug 3 1960 , that (I) (we) last saw the deceased alive on Aug 3 1960 and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Lyle Williams		22b. DATE SIGNED Aug 3, 1960	
22c. PHYSICIAN'S NAME (Type) Lyle Williams		22d. ADDRESS 8700 Colesville Rd - Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		23b. DATE THEREOF 8/6/60	
23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) (State) RICHLAND, W. VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Humphrey, Inc.		25a. REC'D BY REGISTRAR AUG 9 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

10000

RECORD OF DEATH

10000

Washington, D.C. - Hospital - 1901
Name - [illegible]
Age - [illegible]
Sex - [illegible]
Race - [illegible]
Occupation - [illegible]
Cause of Death - [illegible]
Date of Death - [illegible]
Place of Death - [illegible]
Burial - [illegible]
Remarks - [illegible]

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09392

9308

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
f. STREET ADDRESS <u>3410-10th ST. N.E.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cecil F Westover</u>		4. DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>1960</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1889</u>		9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Western Union Tel. Co.</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>			
12. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				13. CITIZEN OF WHAT COUNTRY?			
14. FATHER'S NAME <u>Seymour Westover</u>				15. MOTHER'S MAIDEN NAME <u>Annie M. Gott</u>			
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				17. SOCIAL SECURITY NO. <u>Unknown</u>			
18. INFORMANT <u>Hospital Records, Kensington Gardens</u>				Address			
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Parkinsonson's disease</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/15/60</u> to <u>8/24/60</u> , that (I) (we) last saw the deceased alive on <u>8/13/60</u> , and that death occurred at <u>10</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald Nelson</u>				22b. DATE SIGNED <u>8/24/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>				22d. ADDRESS <u>10620 Georgia Ave. Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		23b. DATE THEREOF <u>8/29/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Agatha Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Crawford Co. Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				25a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>			
25b. REGISTRAR'S SIGNATURE <u>DATE AUG 26 '60</u>				25c. REGISTRAR'S SIGNATURE <u>Robert A. Humphrey</u>			

40302

CERTIFICATE OF DEATH

2008



MADE IN

CHINA

County of [illegible] State of [illegible]

of [illegible] County, State of [illegible]

Donald Nelson



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9422
CERTIFICATE OF DEATH

09393

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Tazewell			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 92 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS Route #1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Geneva Middle Lucy Last White				4. DATE OF DEATH Month August Day 15th Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 12, 1922	
9. AGE (In years lost birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter Sparks				14. MOTHER'S MAIDEN NAME Virginia Compton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Acute lymphoblastic leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 15th , 19 60 to August 15th , 19 60 , that (I) (we) last saw the deceased alive on August 15th , 19 60 , and that death occurred at 10aM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter Oppelt</i>				22b. DATE SIGNED 8-15-60			
22c. PHYSICIAN'S NAME (Type) W. Walter Oppelt, M.D.				22d. ADDRESS The Clinical Center National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal				23b. DATE THEREOF 8/15/60		23c. NAME OF CEMETERY OR CREMATORY Tazewell, Virginia	
23d. LOCATION (City, town, or county) (State) Tazewell, Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		25a. REC'D BY REGISTRAR DATE AUG 16 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>							

80308

CERTIFICATE OF DEATH

9322



Residence: The Clinical Center
Date of Death: 12/15/1952
Age: 38
Sex: Male
Race: White
Marital Status: Single
Cause of Death: Acute myocardial infarction
Place of Death: The Clinical Center
Physician: J. Edgar Hoover

Signature: J. Edgar Hoover
Title: Director, Federal Bureau of Investigation
Date: 12/15/1952
Signature: [Illegible]
Title: [Illegible]
Date: [Illegible]

Signature: [Illegible]
Title: [Illegible]
Date: [Illegible]

Signature: [Illegible]
Title: [Illegible]
Date: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9423

09394

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland 46	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8217 Maple Ridge Rd., Bethesda, Md.			d. STREET ADDRESS 8217 Maple Ridge Rd., Beth., Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JUNIUS Middle ELISHA Last WHITFIELD			4. DATE OF DEATH Month August Day 21 Year 1960		
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 OCT 1879	9. AGE (In years less birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME John Wm. Whitfield, Sr.			14. MOTHER'S MAIDEN NAME Louise Joyner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 231-01-6437A		17. INFORMANT Douglas W. Davis Address 8217 Maple Ridge Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 YRS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from Nov. 20 19 59 , to Aug 21 19 60 , that I (we) last saw the deceased alive on July 28 19 60 , and that death occurred at 9:40 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Robert G. Angle		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug 21, 1960	
22c. PHYSICIAN'S NAME (Type) ROBERT G. ANGLE		22d. ADDRESS 5009 Del Ray Ave. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 23, 1960		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
23d. LOCATION (City, town, or county) _____ (State) _____		23e. REGISTRAR'S SIGNATURE Courtland, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS 7557 Wisconsin Ave.		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Grant		DATE AUG 23 '60			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

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BP

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9424

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09395

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY in 1b <u>55</u>				d. STREET ADDRESS <u>Beck mill Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethesda</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dollie Williams</u>				4. DATE OF DEATH Month Day Year <u>Aug 13 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 4, 1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days <u>10 9</u>		IF UNDER 24 HRS. Hours Min. <u>10 9</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>va</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Geo. Reid</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Ozzie Williams</u>				Address <u>5714 Summer set Cir Bethesda md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO (b) <u>331X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>331X</u> INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous CVA seven yrs ago</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Seven yrs ago</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8-13-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u>				22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 17 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

THE STATE
HEALTH DEPARTMENT
CHICAGO, ILL.

1

Robert A. Emmonsey, Bethesda, Md.
Burial 18/10/20
Rockville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
9425
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09396

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>2 Hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital.</u>		d. STREET ADDRESS <u>1 Oak Crest</u>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>P</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 6, 1897</u>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Fairview, W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John P. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Dolly Toothman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>280-01-3943</u>	
17. INFORMANT <u>Mr. Raymond O. Williams.</u>		<u>1275 Sarslow Avenue Akron, Ohio</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Hyper-tensive Cardio-vascular Disease</u> DUE TO (b) <u>manifest by acute</u> DUE TO (c) <u>left ventricular failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-17-1960</u> to <u>8-17-1960</u> , that (I) (we) last saw the deceased alive on <u>8-17-1960</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Jack Schomacher</u> M.D.		22b. DATE SIGNED <u>8-17-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jack Schomacher</u>		22d. ADDRESS <u>Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-20-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey Jr.</u>		25a. REC'D BY REGISTRAR <u>Frederick, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton L. Kneib</u>		DATE <u>AUG 23 '60</u>	

103308

CERTIFICATE OF DEATH

0425

14

Ministry

England

Northampton

Old Cross

10th Dec 1901

Age

Infant, 10. Virginia

Home

Unborn

John P. Williams

John P. Williams

10th Dec 1901

10th Dec 1901

10

10th Dec 1901

10th Dec 1901

10th Dec 1901

10th Dec 1901

10th Dec 1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09397

Reg. Dist. No.

9426

Item 2 Film 6269 8-25-60 at

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 597 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resmor Sanitarium Hospital		d. STREET ADDRESS Resmor Sanitarium Hospital	
3. NAME OF DECEASED (Type or print) First William Middle C Last Williams		4. DATE OF DEATH Month August Day 16 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1878
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 4 Days 4	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Army		10b. KIND OF BUSINESS OR INDUSTRY Military	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. WW 1 and 2		17. INFORMANT Sanitarium records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Cerebral vascular accident DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 17 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/60	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.
22d. LOCATION (City, town, or county) (State) Arlington, Virginia		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	
24a. REC'D BY REGISTRAR Aug 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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051
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09398

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bethesda Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 1663.2	
		d. STREET ADDRESS 5719 43rd Ave.	
3. NAME OF DECEASED (Type or print) First Noble Middle Jenks Last WILSON		4. DATE OF DEATH Month AUGUST Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-91
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 18 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corp	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence WILSON		14. MOTHER'S MAIDEN NAME Mary PALMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, Meningeal Vessels DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, General DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 mos 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-7- 19 60 , to 8-18- 19 60 , that (I) (we) last saw the deceased alive on 8-18- 19 60 and that death occurred 6:05AM from the causes and on the date stated above.			
22a. SIGNATURE G. I. Walker, Jr.		22b. DATE SIGNED 8-18-60	
22c. PHYSICIAN'S NAME (Type) G. I. WALKER, JR., CAPT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's		25a. REC'D BY REGISTRAR AUG 19 '60	
ADDRESS 4739 Balt. Ave., Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

00338

CERTIFICATE OF THE

0457

Married

Married

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9428

09399

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium 5721 Grosvenor Lane		d. STREET ADDRESS 1435 Kennedy Street N.W.	
3. NAME OF DECEASED (Type or print) Mabel Foote Witman		4. DATE OF DEATH Month August Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Dist. of Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry M. Foote		14. MOTHER'S MAIDEN NAME Emma Waterbus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital Representative		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 446X IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 25 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia (Bronchial & Arteriosclerosis)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1959 to Aug 21 1960 , that (I) last saw the deceased alive on Aug 21 1960 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John B. Marbury		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John B. Marbury		22d. ADDRESS 4545 Conn. Ave. NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/24/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		25a. REC'D BY REGISTRAR AUG 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

00330

MAINTAINING A RECORD OF DEATHS
CERIFICATE OF DEATH

3428



Montgomery

of Alabama

John O. Patterson

Model

White

Female

1

155 Kennedy Street N.E.

Atlanta, Georgia

March 1, 1900

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 9429
 CERTIFICATE OF DEATH

09400
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Bethesda</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1 4620 So. Chelsea Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>S</u> Last <u>Wolfe</u>				4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 4, 1878</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Wolfe</u>				14. MOTHER'S NAME <u>Mary Ryan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-36-8864</u>		INFORMANT <u>Charles A. Walton</u> 4022 Parkwood St. Cottage City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>CORONARY VALVULAR SCLEROSIS</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-31</u> , 19 <u>56</u> to <u>8-8</u> , 19 <u>60</u> that I last saw the deceased alive on <u>August 8</u> , 19 <u>60</u> , and that death occurred at <u>10:15 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Witowski, Jr.</u> M.D.				DATE SIGNED <u>8/8/60</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD S. WITOWSKI, JR.</u>				<u>BETHESDA 14, MARYLAND.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/11/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 11 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

00400

CERTIFICATE OF DEATH

04501

10

Dec. 4, 1975

U.S. Post Office, Washington, D.C.

Mary Ryan

Frank Goffe

1022 Parkwood St. College

570-38-8884 Charles A. Wilson, D.D.

U.S. Post Office, Washington, D.C.

U.S. Post Office, Washington, D.C.

11/11/80 Washington, D.C. 20540

Robert A. Goffe, Director, National Archives and Records Administration

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9309

09401

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 1653-2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 612 Elm Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCIS YARNALL Middle Francis Last Yarnall		4. DATE OF DEATH Month Aug Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1869
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 04 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergy		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Coffin Yarnall		14. MOTHER'S MAIDEN NAME Sarah Rose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT William Dent Yarnall		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, Acute 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile Hemiplegia & Osteoarthritis DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- INTERVAL BETWEEN ONSET AND DEATH 7 days 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 29, 1947 to 14 Aug, 1960 , that (I) (we) last saw the deceased alive on 13 Aug, 1960 , and that death occurred on 14 Aug, 1960 at 4:30 M, from the causes and on the date stated above.			
22a. SIGNATURE M. B. Queen M.D.		22b. DATE SIGNED 14 Aug 1960	
22c. PHYSICIAN'S NAME (Type) M. B. QUEEN		22d. ADDRESS 7112 Willow Ave Takoma Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 16, 1960	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Saville's Inc., Inc. 1756 Pa. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR Aug 16 '60	
25b. REGISTRAR'S SIGNATURE Arthur E. Thomas			

9300

CERTIFICATE OF DEATH

10400

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film 0269 8-17-60 et

9430

09402

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home		d. STREET ADDRESS 5407 Nebraska Ave. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle M Last Yerger		4. DATE OF DEATH Month August Day 13 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/1881
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cassius B. Russell		14. MOTHER'S MAIDEN NAME Anna B. Chase	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - -		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Miss Grace R. Yerger		Address Wash., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mo 3 Yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 50 19 50 to August 13 1960 , that (I) (we) last saw the deceased alive on August 8 1960 , and that death occurred at 8 A M , from the causes and on the date stated above.			
22a. SIGNATURE Harold Heiges MD		22b. DATE SIGNED 8/13/60	
22c. PHYSICIAN'S NAME (Type) Harold Heiges		22d. ADDRESS 1835 Eye St. N.W., Wash, D.C.	
23a. DATE OF CREMATION 8/16/60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE THE S.H. HINES CO - 2901-14th ST. N.W.		25a. REC'D BY REGISTRAR DATE AUG 15 '60	
ADDRESS WASH. D.C.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

00403

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH AND SAFETY
CENTRAL CITY OF BALTIMORE

94-31

(M)

Health Officer

Washington

Washington

Washington Medical Home

1401 K Street, N.W.

Dr. J. C. Smith

Dr. J. C. Smith

Female White

Female White

at home

at home

Charles F. Smith

Charles F. Smith

1

Hotel for the Sick

1401 K Street, N.W.

Harold Holman

1401 K Street, N.W.

U.S. Marine Hospital

U.S. Marine Hospital

U.S. Marine Hospital

U.S. Marine Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN lb 64 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearwater						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNITED STATES NAVAL HOSPITAL-BETHESDA, MD.					d. STREET ADDRESS 709 Edenville Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Doris Middle Grace Last YOUNG					4. DATE OF DEATH Month August Day 20 Year 19 60						
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 JULY 1911		9. AGE (In years last birthday) 49 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Hiram R. Horton					14. MOTHER'S MAIDEN NAME Myrtle Vail						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT William J. Young 709 Edenville Ave Clearwater							
				Address Fla.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Renal Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Carcinoma of Cervix (b) Renal Failure (c) Carcinoma of Cervix										INTERVAL BETWEEN ONSET AND DEATH 2mo 19yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Bowel and Urinary Tract Fistulae										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that XX (this hospital) attended the deceased from June 17, 1960 to Aug 20, 1960 , that (I) (we) last saw the deceased alive on Aug 20, 1960 , and that death occurred at P. M. from the causes and on the date stated above.											
22a. SIGNATURE Paul R. Bauer					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED AUGUST 21, 1960				
22c. PHYSICIAN'S NAME (Type) Paul R. BAUER LT MC USN					22d. ADDRESS USNH Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/23/1960		23c. NAME OF CEMETERY OR CREMATORY Sylvan Abbey Memorial Park			23d. LOCATION (City, town, or county) (State) Clearwater, Florida				
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Young Co. - 1300 N. St. N.W. Wash. D. C.					25a. REC'D BY REGISTRAR AUG 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hunt				

STATE OF NEW YORK
DEPARTMENT OF CORRECTIONS

IN SENATE
January 15, 1913

REPORT OF THE COMMISSIONER OF THE DEPARTMENT OF CORRECTIONS

FOR THE YEAR ENDING DECEMBER 31, 1912

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS, 1913

Price 10 CENTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9298

CERTIFICATE OF DEATH

10549

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park d. STREET ADDRESS 610 Kennebec Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Zarska		4. DATE OF DEATH Month Day Year August 25 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1960
9. AGE (In years last birthday) yrs. 0		IF UNDER 1 YEAR Months 0 Days 0 Hours 1 Min. 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Kenneth Zarska		14. MOTHER'S MAIDEN NAME Carol Louise Stump	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT mother		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 25, 19 60 , to August 25, 19 60 , that I last saw the deceased alive on August 25, 19 60 , and that death occurred at 9:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Herbert D. Glick, M.D. 8301 Piney Branch Road, Silver Spring, Md.			
ACTUAL SIGNATURE Herbert D. Glick, M.D.			
PHYSICIAN'S NAME (Type) Herbert D. Glick, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-2-60	
22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hospital, Takoma Park, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D.		24a. REC'D BY REGISTRAR Washington Sanitarium & Hospital, Takoma Park, Maryland	
24b. REGISTRAR'S SIGNATURE			

VS A15 (4)
15M 9/55

SEP 13 '60

Arthur S. Hare

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

law requires that the death certificate be executed within 24 hours after death. Page 4

after death. Page 4

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9432

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09404

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital			d. STREET ADDRESS 4834 25th RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Amy First Elma Middle ZWICKER Last			4. DATE OF DEATH August 13 1960		
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-11	9. AGE (In years lost birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada	
3. FATHER'S NAME Frank WHYNACHT			14. MOTHER'S MAIDEN NAME Winnie RICHARDSON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Navy records	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE SUBARACHNOID 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 hrs 50 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 8-13-60 to 8-13-60 , that (I) (we) last saw the deceased alive on 8-13-60 at 2:50 PM , and that death occurred at M , from the causes and on the date stated above.						
22a. SIGNATURE William B. Baker		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) W.P. BAKER LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/17/60	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) Suitland, Maryland Arlington, Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE Arlington Funeral Home		ADDRESS 3901 N. Fairfax Dr.		25a. REC'D BY REGISTRAR AUG 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline

Arlington, Virginia

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